2026 BENEFIT GUIDE

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WELCOME TO YOUR 2026 BENEFITS

At Weir, we understand that your benefits play a vital role in supporting your overall well-being. That's why we're committed to providing resources that help you and your family thrive - physically, financially, and emotionally. The benefits outlined in this guide are available to eligible employees and their dependents starting January 1, 2026.

MAKING YOUR CHOICE:

Take time to evaluate your benefit options and anticipated needs to choose the plans that best support your overall well-being while helping you make the most of your budget.

WHAT YOU WILL NEED:

- Social Security Numbers for you and/or your dependents
- Date(s) of birth for you and/or your dependents

- Review enrollment materials
- You have a **30-day** enrollment window starting from your date of hire.
  - If this enrollment period is missed, then you may only enroll if you experience a Qualified Life Event or during Open Enrollment annually
- Benefits are effective on **Date of Hire**
- Seasonal and temporary employees - Eligible following 90-day waiting period
- Designate beneficiaries for Health Savings Account, Life Insurance, AD&D coverage, your 401(k), and Critical Illness, if enrolled
- Complete your enrollment in ADP:
  - Login: **www.website.com**

ELIGIBILITY AND COVERAGE

Weir is proud to offer a comprehensive benefits package to you and your family. You are eligible for Weir benefits if you are:

- Regular, full-time or part-time employee as of your date of hire
- Seasonal or temporary employees following a 90-day waiting period
- Qualified dependents, including Domestic Partners meeting requirements and providing a Domestic Partner Affidavit

If both you and your spouse/domestic partner are benefits-eligible Weir employees, you may enroll in any of the benefit programs as either an employee or a dependent, but not both. Only one of you can cover your eligible dependent child(ren).

DEPENDENT ELIGIBILITY

- Your legal spouse/qualified domestic partner (same or opposite sex);
- Children up to age 26:
  - Including natural, adopted, foster, and/or stepchildren of yours or your spouse/domestic partner, and those a court requires you to cover, such as through a Qualified Medical Child Support Order (QMCSO)
  - Unmarried disabled children of any age, as long as they became disabled before age 26.

MAKING COVERAGE CHANGES DURING THE YEAR

Generally, your benefit coverage stays in effect each year through December 31. However, if you experience a qualifying life event you may change health care elections during the year. Election changes must be submitted within 30 days or 60 days, depending on the type of event. Otherwise, you must wait until the next annual Open Enrollment period to make these changes. Any status change you request must align with the qualifying event and will take effect on the date of that change.

30-DAY ENROLLMENT PERIOD		60-DAY ENROLLMENT PERIOD
CHANGE IN STATUS DUE TO:	**LOSS OF COVERAGE DUE TO:**	
• Marriage, divorce, death of a spouse, legal separation; • Death of a child; • Receipt of a court order such as a QMCSO • Adoption or placement for adoption of a child; or • Gain/loss of dependent eligibility. • Birth of a child.	• Divorce or legal separation; • Death of a spouse or child; • Termination of employment or reduction in work hours; • Taking or returning from unpaid leave of absence; • Employer contributions toward coverage have terminated; or • Exhaustion of COBRA continuation or state continuation.	• Loss of eligibility for coverage under Medicaid; • Loss of eligibility for coverage under a State Children's Health Insurance Program ("SCHIP"); • New eligibility for premium assistance under the Plan for Medicaid or SCHIP.

WHEN COVERAGE ENDS

If you receive a Change in Status that results in a loss of coverage or if you leave Weir, your benefits will terminate as of 11:59 p.m. on the last day of the month in which you terminate. Disability benefits will terminate as of 11:59 p.m. on the last day of employment.

MEDICAL PLAN OVERVIEW

BlueCross BlueShield of Texas

You have access to three medical plan options through BlueCross BlueShield of Texas (BCBSTX), each offering different coverage levels and costs. This flexibility allows you to select the plan that best fits your health needs and financial goals. All medical plans include prescription drug coverage to support your ongoing care and treatment needs.

2026 MEDICAL PLAN OPTION KEY FEATURES

- Comprehensive coverage for a wide range of health care services
- Flexibility to see any provider you want, although you'll save money when you stay in-network
- Free in-network preventive care, with services such as annual physicals, recommended immunizations, well-women and well-child exams, flu shots, and routine cancer screenings
- Teladoc Virtual Primary Care, including Urgent Care and Behavioral Health
- Financial protection through annual out-of-pocket maximums that limit the amount you'll pay each year

WHICH PLAN IS RIGHT FOR YOU?

	HDHP 1	HDHP 2	COPAY PLAN
	HDHP W/HSA	HDHP W/HSA	PPO
Open and contribute to a tax-free HSA, which has no "use it or lose it" rule and offers the opportunity to invest money for future medical costs?	✓	✓	X
Pay the lowest premium cost, which may make it the least expensive option if you expect to have low health care usage?	✓	X	X
Balance your out-of-pocket and paycheck costs with a moderate deductible and premium cost?	X	✓	X
Pay the highest premium cost to keep your out-of-pocket costs as low as possible when you need care?	X	X	✓

SPOUSAL SURCHARGES

If your spouse is eligible for medical coverage through another employer but chooses instead to enroll in one of the Weir medical plans, an additional contribution of $55 per paycheck will apply.

CONSIDERATIONS FOR TOBACCO USERS

If during the past 6 months, you and/or your spouse have used tobacco products including cigarettes, cigars, pipes, e-cigarettes and other forms of smokeless tobacco, your annual medical premium will increase by $XX per paycheck for employee (annual $XX) and $XX per paycheck for spouse (annual $XX).

Members who have completed the BCBSTX Well on Target tobacco cessation program will be eligible for the tobacco surcharge refund for the current plan year upon submission of the program completion certificate to the Weir Benefits Team.

YOUR WELLNESS IS IMPORTANT TO US

MAVEN HEALTH HIGH-RISK MATERNITY CARE SUPPORT

- Engagement with maternity specialists to support members through a high-risk pregnancy
- Eligible members will receive a digital or telephonic outreach from BCBSTX and Maven maternity specialists
- Call BCBSTX at XXX-XX-XX to ask questions or learn more

BCBSTX WELL ON TARGET

- 24/7 access to online resources
- Available to covered employees and dependents
- Tobacco Cessation program available to help you quit!

To Access, register for Blue Access for MembersSM at **www.website.com**

TELADOC TELEHEALTH

- Board-certified doctors available 24/7
- Request immediate consult or schedule appointment
- Offers primary care, dermatology, behavioral health, and urgent care virtual health services
- Costs $48 for HDHP 1 and HDHP 2 until deductible is met, $XX copay for Copay Plan

BCBSTX NURSELINE

- 24/7 access to experienced registered nurses
- Clinicians provide guidance to help understand your health concerns
- Audio library with more than 1,000 pre-recorded health topics
- Call 24/7 Nurseline at XXX-XX-XX

LIVONGO CHRONIC CONDITION MANAGEMENT PLUS PROGRAM

The Livongo through Teladoc Diabetes Management Program includes both Diabetes Prevention and Hypertension Management support for medical enrollees.

DIABETES MANAGEMENT

A personalized way to help manage diabetes. Get tools and support to track blood sugar levels and develop healthier lifestyle habits.

- A connected blood glucose meter
- Unlimited strips and lancets
- Tips, action plans and one-on-one coaching
- Real-time support for out-of-range readings

DIABETES PREVENTION

Take your first step toward a healthier tomorrow, and reduce your risk of type 2 diabetes. With the Diabetes Prevention program, you'll get access to a team of expert coaches, a library of online lessons and a smart scale — at no cost to you.

- Expert coaches to help with diet, nutrition, activity and more
- A smart scale that syncs to the app and web portal
- An all-in-one app to track weight, activity and food

HYPERTENSION MANAGEMENT

Take control of your heart health with guidance and a personalized plan. With a smart blood pressure monitor, you can track, get support, set up reminders and message a coach, all in one place.

- A connected blood pressure monitor
- Step-by-step action plans based on your goals
- Tips on nutrition and activity
- One-on-one support from expert coaches

MEDICAL PLAN COMPARISON

	HDHP 1		HDHP 2		COPAY PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE						
Individual	XX	XX	XX	XX	XX	XX
Family	XX	XX	XX	XX	XX	XX
OUT-OF-POCKET MAXIMUM **Includes deductibles and copays (including pharmacy). After coinsurance is met, the Plan pays 100% for the remainder of the calendar year except where noted.**						
Individual	XX	XX	XX	XX	XX	XX
Family	XX	XX	XX	XX	XX	XX
HEALTH SAVINGS ACCOUNT (HSA) - EMPLOYER CONTRIBUTION						
Individual	XX		XX		XX	
Family	XX		XX		XX	
COINSURANCE/COPAYS						
Primary Care Visit	XX	XX	XX	XX	XX	XX
Specialist Visit	XX	XX	XX	XX	XX	XX
Emergency Room	XX	XX	XX	XX	XX	XX

* Coinsurance after deductible

Please note: If enrolled in a plan with an embedded deductible with others on the plan, each individual must meet their own individual deductible portion before the family deductible is met.

Don't forget your free preventive care! And to avoid additional out-of-pocket costs, always confirm that your providers are in the BCBSTX network.

PRESCRIPTION DRUG PLAN COMPARISON

CVS caremark®

	HDHP 1	HDHP 2	COPAY PLAN
RETAIL PRESCRIPTION DRUGS (30-DAY SUPPLY)			
Generic	XX	XX	XX
Brand Formulary	XX	XX	XX
Non-Formulary	XX	XX	XX
MAIL ORDER DRUGS (90-DAY SUPPLY)			
Generic	XX	XX	XX
Brand Formulary	XX	XX	XX
Non-Formulary	XX	XX	XX

* Coinsurance after deductible

Please note: If enrolled in a plan with an embedded deductible with others on the plan, each individual must meet their own individual deductible portion before the family deductible is met.

GENERIC VERSUS BRAND

- Opt for generic prescriptions or generic equivalents, which contain the same FDA approved ingredients, to save money
- Always check with your doctor to see if a generic alternative is right for you

CVS CAREMARK MAIL ORDER:

- Program to deliver your maintenance and long-term medications right to where you want them
- Remember to ask your doctor for a 90-day supply of the maintenance medications
- **Please note** that mail order may not be available on all prescription medications. Check with Caremark for more information.

CVS CAREMARK SPECIALTY MEDICATIONS:

- Pharmacy to help manage your specialty medication
- Pickup at any CVS Pharmacy

BROAD VACCINE BENEFIT

- Get your COVID-19 and flu shots at no cost to you
- Find network pharmacies at **www.website.com**
- Bring your ID card and valid photo ID

WHAT IS A HDHP W/HSA?

- Did you know that XX% of employers offer high deductible health plans (HDHP)? And over XX% of employees across various employers enroll in an HSA-eligible HDHP.
- A HDHP is regulated by the IRS and does not allow for first dollar coverage, except for certain preventive services. That means, you pay for the cost of health care services until you have met your deductible. Then you share in the cost of services with Weir until your out-of-pocket maximum has been met.
- The HDHP costs you less from your paycheck, so you keep more of your money. This plan rewards you for taking an active role as a health care consumer and making smart decisions about your health care spending.

USING AN HDHP

FREE PREVENTIVE CARE	DEDUCTIBLE	COINSURANCE	OUT-OF-POCKET MAXIMUM
You pay nothing for in-network preventive care.	You pay your medical expenses up to the annual deductible amount. Use your HSA to plan ahead for these costs and save money by paying with tax-free dollars.	After meeting your deductible, the plan starts to pay coinsurance. You'll only pay a percentage of each bill.	You're protected by an annual limit on costs. The plan pays 100% once you've paid this amount during the year.

HSA ELIGIBILITY

- Enrolled in HDHP 1 or HDHP 2.
- You are not eligible for an HSA, if:
  - Covered by any other medical plan that is not a qualified HDHP, including a spouse's non-HDHP coverage.
  - Enrolled in a traditional healthcare FSA in 2026.
  - Enrolled in Medicare, including Parts A or B, Medicaid, or Tricare.
  - Currently claimed as a dependent on another person's tax return.

THE VALUE OF A HDHP W/HSA

hsabank own your health℠

HOW DOES AN HSA WORK?

The HSA is a special bank account owned by you to help save pre-tax dollars for current and future health care expenses. It gives you more control over your health care spending.

START IT.	BUILD IT.	USE IT.	SAVE IT.
If you enroll in HDHP 1 or HDHP 2, an account will be automatically opened for you through HSA Bank.	Add to your account with your own pre-tax contributions, up to IRS limits. Weir contributes, too!	Use the HSA funds to pay for covered health care expenses for yourself and your eligible dependents.	There is no "use-it-or-lose-it" rule – you can carry over your HSA funds from year to year for future expenses. You can even take it with you when you leave or retire from Weir.

Both you and Weir can make contributions to your account for 2026 up to the annual IRS limit of:

- Up to **XX** for employee only
- Up to **XX** for family
- Add **XX** to these limits if you are 55 years or older

Weir will contribute the amounts below for 2026 to your HSA to help you pay your qualified out-of-pocket expenses. Please note these amounts reflect Weir's total annual HSA contributions. Contributions will be distributed evenly per paycheck throughout the year.

- **HDHP 1:** $XX employee only / XX family
- **HDHP 2:** $XX employee only / XX family

DESIGNATE YOUR BENEFICIARY

Since an HSA is owned by you, a beneficiary must be on file with HSA Bank.

To designate a beneficiary with HSA Bank, follow these simple steps:

1. Go to member website at **www.website.com**
2. Log into your account and click on **Profile** tab
3. Click **Add Beneficiary**
4. Provide beneficiary information and **Submit**

This is the only plan that features a triple tax advantage – contributions are tax-free, investment earnings are tax-free, and withdrawals are tax-free.

FLEXIBLE SPENDING ACCOUNTS*

Flexible Spending Accounts (FSAs) are great ways to save on your everyday expenses. You avoid paying income taxes on the amount you contribute to the FSA because the money comes out of your paycheck before federal, state, and Social Security taxes are calculated - and it's not taxed when you use it to pay for eligible expenses.

HEALTH CARE FSA

- Pay for medical, dental, and vision expenses, such as deductibles and co-insurance. To learn more, see IRS publication 502 at **www.website.com.**
- Contribute between $XX and the 2026 IRS limit, per year
- Your entire annual contribution amount is available to you from the beginning of the plan year

DEPENDENT DAY CARE FSA

- Reimburse day care for eligible dependents. To learn more, see IRS Publication 503 at **www.website.com**
- Contribute between XXXX - XXXX (XX if you're married filing a separate tax return)
- Reimbursements can be made after each contribution by uploading receipts to the WEX portal
- Dependent Day Care FSA can be used on any eligible dependents age 13 years or younger

Remember!

Unclaimed funds in your account will be forfeited as required by the IRS, so estimate your future spending carefully!

WEX Benefits Card

If reenrolling for 2026, your current card will be automatically loaded with your 2026 annual election amount. New cards will be issued to new participants and participants whose debit card has expired.

* These are 2025 limits. The limits for 2026 had not been announced when this guide was published.

SPENDING ACCOUNT COMPARISON

HSA VS FSA: WHAT'S THE DIFFERENCE?

	HEALTH SAVINGS ACCOUNT	HEALTH CARE FLEXIBLE SPENDING ACCOUNT*	DEPENDENT DAY CARE FLEXIBLE SPENDING ACCOUNT*
Providers	XX	XX	XX
Eligibility	HDHP 1 or HDHP 2	Benefits-eligible employees not enrolled in HSA	Benefits-eligible employees with eligible dependents
Covered Expenses	Medical, Pharmacy, Dental, Vision	Medical, Pharmacy, Dental, Vision	Childcare up to 13 years and Eldercare
Contribution Limits	XX individual XX family per year Plus XX for 55+	Up to the IRS Limits for 2026	XX individual/married filing jointly XX married filing separately
Company Contribution	Yes	No	No
Use-it-or-Lose-it	No	Yes	Yes

*These are 2025 limits. The limits for 2026 had not been announced when this guide was published.

DENTAL PLAN COMPARISON

DELTA DENTAL®

Good dental care not only keeps your mouth healthy, but also contributes to your overall health. Benefits for the Low and High in-network providers are shown below. Out-of-network coverage is also available, but you will pay slightly more since coverage is based on reasonable and customary charges rather than negotiated fees.

	LOW (BASIC DPPO)	HIGH (PREMIUM DPPO)
	IN-NETWORK	IN-NETWORK
Annual Deductible		
Individual	XX	XX
Family	XX	XX
Calendar-year maximum	XX per person	XX per person
Preventive/diagnostic services	Plan pays XX, no deductible	Plan pays XX, no deductible
Basic services	Plan pays XX, after deductible	Plan pays XX, after deductible
Major services	Plan pays XX, after deductible	Plan pays XX, after deductible
Orthodontia Up to age 26	Plan pays XX, after deductible	Plan pays XX, after deductible

VISION PLAN OVERVIEW

vsp vision care

To help you keep your vision strong and eyes healthy, vision coverage through VSP includes annual exams and corrective treatment. The coverage saves you money on eligible vision care expenses such as eye exams, glasses, and contact lenses.

	IN-NETWORK	OUT-OF-NETWORK
Exam (once every plan year)	XX copay	Reimbursed up to XX
Lenses (once every plan year)	XX copay	Reimbursed up to X (single vision) Reimbursed up to X (bifocal) Reimbursed up to X (trifocal)
Frames (once every plan year)	XX allowance; XX off the amount over your allowance, after XX copay	Reimbursed up to XX
Contact Lenses		
Fitting (standard)	XX copay	Not covered
Elective	XX allowance	Up to XX
Medically Necessary	XX copay, Paid in full	Up to XX

Additionally, save up to XXXX on Brand-Name Hearing Aids through VSP's exclusive member extra partnership with TruHearing.

GLASSES AND SUNGLASSES

- Extra XX to spend on featured frame brands. Go to **www.website.com** for details.
- XX savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.

RETINAL SCREENING

- No more than a XX copay on routine retinal screening as an enhancement to a WellVision Exam.

LASER VISION CORRECTION

- Average XX off the regular price or XX% off the promotional price. Discounts are only available from contracted facilities.

EMPLOYEE ASSISTANCE PROGRAM

TELUS Health

When balancing the demands of family, job, and personal needs, Weir-provided Employee Assistance Program (EAP) can help. The EAP is staffed by licensed professionals who are available to guide you and get you the right resources to deal with your personal, household, and family issues. You have access to 5 visits per issue per year. Turn to this confidential, no-cost service 24 hours a day, 7 days a week, for support provided through a wide range of resources to assist you in managing everyday concerns.

TELUS Health EAP and well-being resource is available 24/7 by phone, online and by mobile app.

EXAMPLES OF SUPPORT:

- **STRESS AND OVERLOAD**
- **ESTATE PLANNING AND WILLS**
- **ANXIETY AND DEPRESSION**
- **ADDICTION AND SEPARATION**
- **GRIEF AND LOSS**

FINANCIAL SECURITY – LIFE AND AD&D INSURANCE

In case the unexpected happens, life insurance and disability coverage offer you and your family financial support and peace of mind.

BASIC LIFE AND AD&D INSURANCE

You automatically receive basic life and accidental death and dismemberment (AD&D) insurance. This is completely paid for by Weir.

- Benefit amount: 2X annual earnings, max of XX
- If your Basic Life coverage is over XX, federal tax rules require that the value of the amount above XX be considered "imputed income," which is taxable. The amount will appear as Group Term Life (GTL) on your pay stubs and your Form W-2.

OPTIONAL LIFE AND AD&D INSURANCE

You can supplement the Basic Life/AD&D policy by purchasing Optional coverage for you and your eligible dependents.

OPTIONAL COVERAGE	SUMMARY OF COVERAGE
Employee Life	XX increments up to XX or 6X annual pay, whichever is less
Spouse/Domestic Partner Life	XX increments up to XX
Child(ren) Life	XX increments up to XX
Employee AD&D	XX increments up to XX or 10X annual pay, whichever is less
Spouse/Domestic Partner AD&D	XX increments up to XX
Child(ren) AD&D	XX increments up to XX

EVIDENCE OF INSURABILITY (EOI)

EOI is required for Optional Life Insurance coverage in the following situations:

- You elect or increase optional coverage for you or your spouse/domestic partner for any amount after the initial New Hire enrollment period.
- You declined optional coverage for you or your spouse/domestic partner in the past, but now you want to enroll.

If applicable, you must submit your EOI to Voya. Coverage is effective after approval from the underwriter.

LIMITATIONS ON LIFE INSURANCE

Once certain ages are reached, plan provisions may change.

GUARANTEED ISSUE

Guaranteed issue refers to the maximum level of coverage you can elect without providing an EOI. An EOI will be required for amounts in excess of the guaranteed issue amount. Guaranteed issue is up to XX for employees and XX for spouses.

FINANCIAL SECURITY – LIFE AND AD&D INSURANCE

VOYA FINANCIAL™

UPON SEPARATION OF EMPLOYMENT

You may be eligible to port or convert your basic coverage and port or convert your optional life coverage(s) for you, your spouse and child. To be eligible to port coverage, you must have been actively at work on the date employment ended. You must complete an application and apply for these options within 31 days of your coverage termination. To obtain an application, contact Voya.

OPTIONAL LIFE

- Spouse Life maximum not to exceed the combined total of the employee's basic and optional life amounts.
- Employee does not have to be enrolled in Optional Life to enroll their spouse or child.
- Amounts can be elected in increments of XX for employees and spouse, and XX for children.

BENEFICIARY DESIGNATION

When you enroll in life insurance, whether it is paid for by Weir or you, you must name a beneficiary. Your beneficiary is entitled to receive benefits if you die while covered under Weir Life Insurance/ AD&D plans. You may name anyone you wish as your beneficiary, and you may change your beneficiary at any time. Important: The employee is the primary beneficiary for Optional Spouse/Child(ren) Life and AD&D plans. Log in to ADP at **www.website.com** and click on Myself > Personal Information > Dependents & Beneficiaries to add or edit your beneficiaries.

FINANCIAL SECURITY – DISABILITY INSURANCE

The loss of income due to illness or disability can cause serious financial hardship for your family. Weir's disability insurance programs work together to replace a portion of your income when you're unable to work. The disability benefits you receive allow you to continue paying your bills and meeting your financial obligations during this difficult time.

	SHORT-TERM DISABILITY	BASIC LONG-TERM DISABILITY	BUY-UP LONG-TERM DISABILITY
Cost	Company paid; automatically enrolled	Company paid; automatically enrolled	Employee Paid
Benefit provided	Replaces XX% of weekly earnings up to XX/week, reduced by any other eligible income	Replaces XX% of monthly earnings; up to a maximum of XX	Replaces XX% of monthly earnings up to a maximum of XX
Duration of disability	25 weeks, following 7-day elimination period	Until you're no longer considered disabled or you reach normal retirement age, whichever comes first	Until you're no longer considered disabled or you reach normal retirement age, whichever comes first

IMPORTANT INFORMATION ABOUT YOUR LONG-TERM DISABILITY INSURANCE PLAN

A pre-existing condition evaluation is required on a Long-Term Disability (LTD) claim if your date of disability falls within the first twelve (12) months of coverage.

You have a pre-existing condition if:

- You received medical treatment, consultation, care or services, including diagnostic measures, or took prescribed drugs or medicines in the three (3) months just prior to your effective date of coverage; and
- The disability begins in the first twelve (12) months after your effective date of coverage.

If you have additional questions about pre-existing conditions, please reach out to Voya.

ENHANCED MATERNITY LEAVE

We know how important it is to support new mothers after childbirth, so Weir offers a 12-week paid leave benefit.

VOLUNTARY BENEFITS

Weir offers additional benefits that supplement the core health insurance programs and are employee-paid through payroll deductions. These benefits can be a cost-efficient and convenient way to provide additional coverage to you and your family.

ACCIDENT INSURANCE

Accident Insurance can pay a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur on and off the job. And it includes a range of incidents, from common injuries to more serious events.

Why is this coverage so valuable?

- It can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles.
- You're guaranteed base coverage, without answering health questions.
- The cost is conveniently deducted from your paycheck.
- You can keep your coverage if you change jobs or retire. You'll be billed directly.

CRITICAL ILLNESS INSURANCE

If you're diagnosed with an illness that is covered by this insurance, you can receive a lump sum benefit payment. You can use the money however you want.

Why is this coverage so valuable?

- The money can help you pay out-of-pocket medical expenses, like co-pays and deductibles.
- You can use this coverage more than once.

Even after you receive a payout for one illness, you're still covered for the remaining conditions and for the reoccurrence of any critical illness with the exception of skin cancer. The occurrence benefit pays 100% of your coverage amount. Diagnoses must be at least 180 days apart or the conditions can't be related to each other.

HOSPITAL INDEMNITY

Pays a set amount when you're admitted to the hospital. The money is paid directly to you to use however you wish.

What does it cover?

- Hospital admission – XX or XX per insured, paid once a year
- Daily hospital confinement – XX or XX per day to a maximum of 365 days per year
- ICU admission – XX or XX per insured, paid once per year
- ICU daily stay – XX or XX per day to a maximum of 15 days per year

ADDITIONAL BENEFITS

AUTO DISCOUNT PROGRAM

Partner Recognition X-Plan Vehicle Pricing Program

As an employee of Weir, you are eligible to participate in the Partner Recognition X-Plan Vehicle Pricing Program! This exciting program offers Weir employees and their household members the opportunity to purchase or lease eligible vehicles with Ford Motor Company's special X-Plan pricing which is pre-determined based on dealer invoice and varies by brand. One Low Price - No Haggling and No Hassle. Just log on to **www.website.com** and enter the Weir Group, Inc. Partner Code (VM638), then click on Generate a PIN and complete steps 1-3.

Chrysler Affiliate Rewards Program

Through the Affiliate Rewards program, Weir employees are eligible to purchase or lease most, new Chrysler, Jeep, Dodge, RAM and FIAT vehicles at the 'Preferred Price' which is X% below dealer invoice. Combine this great discount opportunity with current incentives to save thousands off Manufacturer's suggested Retail Price (MSRP). You will pay a $75.00 fee to participate in this program. Log on to **www.website.com** and enter the Weir Group, Inc. Company Code (F00G09) or call XXX-XX-XX.

BRIGHT HORIZONS FAMILY SOLUTIONS

Weir has partnered with Bright Horizons Family Solutions program to offer you and your family high-quality back-up child and adult/elder care, plus access to regular caregivers, pet care, tuition discounts, and more.

Bright Horizons Back-Up Care

High-quality replacement care will provide employees with 10 days of care for your child or adult/elder relative when regular arrangements fall through. You will be able to get immediate access to family care for all ages throughout the U.S. and be able to reserve care up to 30 days in advance, or on the actual day care is needed. If Bright Horizons is unable to secure care through a current network provider, or there are no network options available in your area, you will have the option to choose your own care provider and get reimbursed for back-up care days you use, up to XX per day.

Care For The Whole Family

Easily find nannies and sitters; elder care resources, planning and referrals; pet sitters, dog walkers, and groomers (your membership to the comprehensive database is waived!); jump ahead on a wait list at a Bright Horizons center or enjoy discounts at participating child care centers as well as tutoring and test prep services.

ADDITIONAL BENEFITS

LEGAL BENEFITS

An UltimateAdvisor legal insurance plan from ARAG® covers a wide range of legal needs. Work with a network attorney and attorney fees are 100% paid in-full for most covered matters. Access more than 14,000 attorneys within ARAG's network with an average of 20 years of experience. Use DIY Docs® to create any of the 350+ legally valid documents, including state-specific templates.

PET INSURANCE

Now more than ever, pets are playing a significant role in our lives and it is important to keep them safe and healthy. Pet insurance offered by MetLife is simple, flexible and helps ensure that you can care for your pets.

PET INSURANCE PLAN

MetLife
www.website.com
XXX-XX-XX

Enrollment in the Auto, Home and Pet Insurance plans must be completed directly with MetLife or Farmers Insurance Choice as applicable. Enrollments for these plans are not available in ADP.

AUTO AND HOME INSURANCE

Farmers Insurance Choice is a powerful tool that enables you to quickly and easily compare and save on auto, home and renters insurance. With the click of a button or a phone call, Farmers Insurance Choice can provide you with multiple competitive quotes from highly-rated carriers customized to your needs. Choose the coverage that's right for you.

AUTO AND HOME INSURANCE PLAN

Farmers Insurance Choice
www.website.com
XXX-XX-XX

ID PROTECTION

Allstate Identity Protection proactively monitors your identity and will alert you of potential fraudulent activity. Through Allstate Identity Protection, you will also have the power to create financial thresholds for debits from your bank accounts, allowing you to receive alerts for potentially suspicious financial transactions outside of your set limits. We monitor your credit reports and credit-related accounts and we monitor the dark web to check for your compromised credentials that could lead to unauthorized account access. While we can't prevent fraud, we can and do alert you at its first known sign, then remediate the fraud and restore your identity.

FINANCIAL SECURITY – 401(K) RETIREMENT PLAN

Vanguard®

It's important to plan for your family's financial security. We offer a 401(k) Plan with Weir match to help you save for retirement.

Full-time and part-time employees are eligible to enroll in the plan on the first business day of the month following your date of hire. When you become eligible, Vanguard will mail you information regarding automatic enrollment. If you take no action, you will be automatically enrolled at 3% pretax on the first pay period following 45 days after your eligibility date.

If you do not want to participate, contact Vanguard within 45 days of your hire date to opt out before payroll deductions occur.

The plan also has an auto-increase of your deferral rate at 1% annually, effective each March.

PROVISION	DESCRIPTION
Employee Contributions	• Contribute from X% to X% of your pay on a pre-tax, traditional after-tax, and/or 401(k) Roth basis • Those age 50 or older can make catch-up contributions above the normal IRS annual limit
Company Contributions	Weir will match X% of your payroll deducted employee contributions up to X% of your eligible compensation
Rollovers	Contact Vanguard to rollover money into this plan from a former employer's eligible plan or a qualifying IRA.
Vesting	You are always X% vested in your own contributions, company matching, and any earnings. Vesting refers to your right of ownership to the money in your account.
Funds	The complete lineup of investment options is available at **www.website.com.**

For current IRS limits, visit www.website.com.

All investing is subject to risk, including possible loss of the money you invest.

CONTACT INFORMATION

FOR QUESTIONS ABOUT...	ADMINISTRATOR	WEB ADDRESS PLAN/GROUP ID
HR Shared Services	XXX	www.website.com
Medical Plan	XXX	www.website.com
Chronic Condition Management Program	XXX	www.website.com
Pharmacy Plan	XXX	www.website.com
Dental Plan	XXX	www.website.com
Vision Plan	XXX	www.website.com
Health Savings Accounts	XXX	www.website.com
Flexible Spending Accounts	XXX	www.website.com
Life/AD&D and Disability Insurance	XXX	www.website.com
Leave of Absence	XXX	www.website.com
VOLUNTARY BENEFITS		
Auto and Homeowners Insurance	XXX	www.website.com
Critical Illness, Accident, and Hospital Indemnity plans	XXX	www.website.com
Identity Theft Protection	XXX	www.website.com
Legal Insurance	XXX	www.website.com
Pet Insurance	XXX	www.website.com
ADDITIONAL BENEFITS		
Bright Horizons	XXX	www.website.com
Employee Assistance Program (EAP)	XXX	www.website.com
Auto Discount Programs	XXX	www.website.com
Husk Gym Network	XXX	www.website.com
401(k) Retirement Plan	XXX	www.website.com

ENROLLING IN YOUR BENEFITS – HOW TO ENROLL

TAKE ACTION!

- After your initial enrollment, changes can only be made due to qualifying life events, such as marriage, divorce, birth, adoption, or a change in your spouse's employment status
- **New employees:** Enroll within 30 days from your date of hire
- Additional benefit materials, such as plan summaries, are available in ADP

WHERE DO I SEE MY BENEFITS?

Login by going to:
www.website.com

Click User Login then enter your User ID and Password

xxx@xxx
Example: xxx@xxx

ESCO Employees use your benefits ADP login

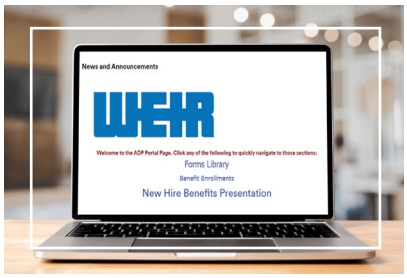
(This is different from your ADP login for payslips)

NEED MORE INFORMATION?

Contact HR Customer Service
888-974-4727 or access HR Service Now

www.website.com

Once you login, click **"Contact HR"** to submit your service ticket



ID CARDS

PLAN ADMINISTRATOR	2026 ID CARD
BlueCross BlueShield Medical Plans	New ID cards provided to all enrollees
CVS Caremark Prescription Drug Coverage	No ID cards, your medical plan ID card includes your prescription coverage
Delta Dental Plans	New ID cards provided to new enrollees
VSP Vision Plans	No ID cards, you give your Social Security Number
HSA Bank Health Savings Account	New debit cards provided to new enrollees or when your current card expires
WEX Flexible Spending Accounts	New debit cards provided to new enrollees or when your current card expires

IMPORTANT NOTICE

Important notice to employees from Weir Group, PLC about creditable prescription drug coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Weir Group, PLC medical plan are expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2026. This is known as "creditable coverage."

Why this is important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2026 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with Weir Group, PLC and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Notice of creditable coverage

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the Weir Group, PLC prescription drug plans, you'll be interested to know that the prescription drug coverage under the plans is, on average, at least as good as standard Medicare prescription drug coverage for 2026. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the Weir Group, PLC plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Weir Group, PLC coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment or other qualifying event, or otherwise become newly eligible to enroll in the Weir Group, PLC plan mid-year, assuming you remain eligible.

You should know that if you waive or leave coverage with Weir Group, PLC and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this Weir Group, PLC coverage changes, or upon your request.

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. Medicare

participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit **www.website.com** for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number) or visit the program online at **www.website.com**.
- Call XXX-XX-XX TTY users should call XXX-XX-XX.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at **www.socialsecurity.gov** or call XXX-XX-XX

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact: HR Shared Services XXX-XX-XX

SUMMARY ANNUAL REPORT
Weir Group, Inc. Welfare Benefit Plan

This is a summary of the annual report of the Weir Group, Inc. Welfare Benefit Plan, XXX, for period 01/01/2024 through 12/31/2024. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Weir Group, PLC has committed itself to pay certain self-insured Medical, Prescription Drug, Flexible Spending Account, Dental, and Short-term Disability claims incurred under the terms of the plan.

Insurance Information
The plan has contracts with Telus Health (US) Ltd., Vision Service Plan, Reliastar Life Insurance Company, Cigna Health and Life Insurance Company, Life Insurance Company of North America, BlueCross BlueShield of Illinois, and Delaware American Life Insurance Company of America to pay Medical, Prescription Drug, Dental, Vision, Life Insurance, Short-term Disability, Long-term Disability, Accidental Death and Dismemberment, Employee Assistance Program, Critical Illness, Accident, hospital indemnity, and evacuation claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2024 were $XX

Your Rights to Additional Information
You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- Insurance information, including sales commissions paid by insurance carriers;

To obtain a copy of the full annual report, or any part thereof, write or call the office of Weir Group, PLC at 1631 NW Thurman St., Suite 102, Portland, OR, 97209 or by telephone at XXX-XX-XX.

You also have the legally protected right to examine the annual report at the main office of the plan (Weir Group, PLC, 1631 NW Thurman St., Suite 102, Portland, OR, 97209) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Or you may access a copy on the DOL's website **www.website.com**.

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.website.com**.

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.website.com** 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.website.com** 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 –

Alabama – Medicaid
Website: **http://myalhipp.com/** Phone: 1-855-692-5447
Alaska – Medicaid
The AK Health Insurance Premium Payment Program Website: **http://myakhipp.com/** Phone: 1-866-251-4861 Email: **CustomerService@MyAKHIPP.com** Medicaid Eligibility: **https://health.alaska.gov/dpa/Pages/default.aspx**
Arkansas – Medicaid
Website: **http://myarhipp.com/** Phone: 1-855-MyARHIPP (855-692-7447)
California – Medicaid
Health Insurance Premium Payment (HIPP) Program Website: **http://dhcs.ca.gov/hipp** Phone: 916-445-8322 Fax: 916-440-5676 Email: **hipp@dhcs.ca.gov**
Colorado – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: **https://www.healthfirstcolorado.com/** Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: **https://hcpf.colorado.gov/child-health-plan-plus** CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): **https://www.mycohibi.com/** HIBI Customer Service: 1-855-692-6442

Florida – Medicaid
Website: **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html** Phone: 1-877-357-3268
Georgia – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra** Phone: 678-564-1162, Press 2
Indiana – Medicaid
Health Insurance Premium Payment Program All other Medicaid Website: **https://www.in.gov/medicaid/** **http://www.in.gov/fssa/dfr/** Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
Iowa – Medicaid and CHIP (Hawki)
Medicaid Website: **Iowa Medicaid | Health & Human Services** Medicaid Phone: 1-800-338-8366 Hawki Website: **Hawki - Healthy and Well Kids in Iowa | Health & Human Services** Hawki Phone: 1-800-257-8563 HIPP Website: **Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)** HIPP Phone: 1-888-346-9562

IMPORTANT NOTICE

Kansas – Medicaid
Website: **https://www.kancare.ks.gov/** Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
Kentucky – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx** Phone: 1-855-459-6328 Email: **KIHIPP.PROGRAM@ky.gov** KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: **https://chfs.ky.gov/agencies/dms**
Louisiana – Medicaid
Website: **www.medicaid.la.gov** or **www.ldh.la.gov/lahipp** Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
Maine – Medicaid
Enrollment Website: **https://www.mymaineconnection.gov/benefits/s/?language=en_US** Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: **https://www.maine.gov/dhhs/ofi/applications-forms** Phone: 1-800-977-6740 TTY: Maine relay 711
Massachusetts – Medicaid and CHIP
Website: **https://www.mass.gov/masshealth/pa** Phone: 1-800-862-4840 TTY: 711 Email: **masspremassistance@accenture.com**
Minnesota – Medicaid
Website: **https://mn.gov/dhs/health-care-coverage/** Phone: 1-800-657-3672
Missouri – Medicaid
Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm** Phone: 573-751-2005
Montana – Medicaid
Website: **http://dphhs.mt.gov MontanaHealthcarePrograms/HIPP** Phone: 1-800-694-3084 Email: **HHSHIPPProgram@mt.gov**
Nebraska – Medicaid
Website: **http://www.ACCESSNebraska.ne.gov** Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada – Medicaid
Medicaid Website: **http://dhcfp.nv.gov** Medicaid Phone: 1-800-992-0900

New Hampshire – Medicaid
Website: **https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program** Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: **DHHS.ThirdPartyLiabi@dhhs.nh.gov**
New Jersey – Medicaid and CHIP
Medicaid Website: **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/** Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: **http://www.njfamilycare.org/index.html** CHIP Phone: 1-800-701-0710 (TTY: 711)
New York – Medicaid
Website: **https://www.health.ny.gov/health_care/medicaid/** Phone: 1-800-541-2831
North Carolina – Medicaid
Website: **https://medicaid.ncdhhs.gov/** Phone: 919-855-4100
North Dakota – Medicaid
Website: **https://www.hhs.nd.gov/healthcare** Phone: 1-844-854-4825
Oklahoma – Medicaid and CHIP
Website: **http://www.insureoklahoma.org** Phone: 1-888-365-3742
Oregon – Medicaid
Website: **http://healthcare.oregon.gov/Pages/index.aspx** Phone: 1-800-699-9075
Pennsylvania – Medicaid and CHIP
Website: **https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html** Phone: 1-800-692-7462 CHIP Website: **https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx** CHIP Phone: 1-800-986-KIDS (5437)
Rhode Island – Medicaid and CHIP
Website: **http://www.eohhs.ri.gov/** Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
South Carolina – Medicaid
Website: **https://www.scdhhs.gov** Phone: 1-888-549-0820
South Dakota - Medicaid
Website: **http://dss.sd.gov** Phone: 1-888-828-0059

Texas – Medicaid
Website: **https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program** Phone: 1-800-440-0493
Utah – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: **https://medicaid.utah.gov/upp/** Email: **upp@utah.gov** Phone: 1-888-222-2542 Adult Expansion Website: **https://medicaid.utah.gov/expansion/** Utah Medicaid Buyout Program Website: **https://medicaid.utah.gov/buyout-program/** CHIP Website: **https://chip.utah.gov/**
Vermont – Medicaid
Website: **https://dvha.vermont.gov/members/medicaid/hipp-program** Phone: 1-800-250-8427
Virginia – Medicaid and CHIP
Website: **https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select** **https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs** Medicaid/CHIP Phone: 1-800-432-5924

Washington – Medicaid
Website: **https://www.hca.wa.gov/** Phone: 1-800-562-3022
West Virginia – Medicaid and CHIP
Website: **https://dhhr.wv.gov/bms/** **http://mywvhipp.com/** Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
Wisconsin – Medicaid and CHIP
Website: **https://www.dhs.wisconsin.gov badgercareplus/p-10095.htm** Phone: 1-800-362-3002
Wyoming – Medicaid
Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/** Phone: 1-800-251-1269

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
www.website.com
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.website.com
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040.
OMB Control Number 1210-0040 (expires 03/31/2026)

Weir Group, PLC HIPAA privacy notice

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

IMPORTANT NOTICE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Weir Group, PLC health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you
The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Weir Group, PLC as an employer — that's the way the HIPAA rules work. Different policies may apply to other Weir Group, PLC programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information
The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- Payment includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- Health care operations include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with Weir Group, PLC
The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Weir Group, PLC for plan administration purposes. Weir Group, PLC may need your health information to administer benefits under the Plan. Weir Group, PLC agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Weir Group HR Shared Services are the only Weir Group, PLC employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and Weir Group, PLC, as allowed under the HIPAA rules:
- The Plan, or its insurer or HMO, may disclose "summary health information" to Weir Group, PLC, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to Weir Group, PLC information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Weir Group, PLC cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Weir Group, PLC from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information
In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protective services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	dditional Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

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The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights
You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse
You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information
If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information
With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete
With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Right to receive an accounting of disclosures of your health information
You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request
You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice
The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on 1/1/2026. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice.

Complaints
If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, contact HR Shared Services at XXX-XX-XX.

Contact
For more information on the Plan's privacy policies or your rights under HIPAA, contact HR Shared Services at XXX-XX-XX.

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Women's Health and Cancer Rights Act 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.

Newborns' and Mothers' Health Protection Act notice

Group health plans and health insurance issuers generally may not, under 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, Federal law 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, plans and issuers may not, under 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). If you would like more information on maternity benefits, call HR Shared Services at XXX-XX-XX.

Notice of Special Enrollment Rights for Medical plan coverage

As you know, if you have declined enrollment in Weir Group, PLC's medical plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plan without waiting for the next open enrollment period, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Weir Group, PLC will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the Weir Group, PLC group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another medical plan.

Michelle's Law notice – Extended dependent medical coverage during student medical leaves

The medical plans may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from a post-secondary educational institution (including a college or university). Coverage may continue for up to a year, unless the child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school – or change in school enrollment status (for example, switching from full-time to part-time status) – starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If the coverage provided by the plan is changed during this one-year period, the plan will provide the changed coverage for the remainder of the leave of absence.

HIPAA Privacy notice reminder

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require the Weir Group PLC Health and Welfare Benefit Plan (the "Plan") to periodically send a reminder to participants about the availability of the Plan's Privacy Notice and how to obtain that notice. The Privacy Notice explains participants' rights and the Plan's legal duties with respect to protected health information (PHI) and how the Plan may use and disclose PHI.

To obtain a copy of the Privacy Notice contact HR Shared Services at XXX-XX-XX.

Fixed Indemnity Plan Notice

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit HealthCare.gov or call XXX-XX-XX to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your state Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Wellness Program Notices

Weir Group has 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.

Additional incentives of up to $600 per year for employees and $300 per year for spouses may be available for employees who have no intention to use tobacco for the next twelve months 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 HR Shared Services.

GINA Spousal Notice and Authorization for Wellness Program

You are receiving this Notice and Authorization because Weir Group, PLC is making a voluntary wellness program available to you as the spouse of an employee or retiree. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve health or prevent disease, including the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as applicable, among others. Your spouse who is an employee of Weir Group, PLC will receive a separate Notice regarding the wellness program.

Federal law requires that you provide knowing, written, and voluntary authorization prior to Weir Group, PLC's wellness program collecting your genetic information, which includes information about your current or past health status. By signing this Notice and Authorization, you are agreeing that you have read and understood it and that you are knowingly and voluntarily providing information about the manifestation of your diseases and certain other conditions as well as your family medical history – considered genetic information – as part of the wellness program. This may include a medical questionnaire 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 may also be asked to complete a medical examination (e.g., a biometric screening). If you are unable to participate in any of the health-related activities,

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you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting HR Shared Services.

You are not required to complete the questionnaire or the medical examination. You are not required to provide genetic information; however, if you choose not to provide information regarding your own health status, you may not qualify for the full amount of wellness incentives (which may include reduced Weir Group, PLC medical plan premiums). The wellness program cannot offer you a wellness incentive in return for you providing your own genetic information, including your family medical history, results of your genetic tests, or information about your children's health status or genetic information. Regardless, you and/or your spouse will not be denied access to Weir Group, PLC's health plan (or any package of health plan benefits), or subjected to Weir Group, PLC discrimination or retaliation if you choose not to participate in the wellness program.

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. You also are encouraged to share your results or concerns with your own doctor.

We are required by law to maintain the privacy and security of your individually identifiable genetic or medical information.

Here is a summary of how we will protect your confidentiality and restrict disclosure of your information:

- Weir Group, PLC will retain all enrollment and incentive eligibility materials. Information stored electronically will be protected, 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. If a data breach occurs involving your information, you will be notified.
- Your individually identifiable genetic or medical information will be provided only to you (or a family member whom you authorize) and licensed health care professionals and staff involved in providing services under the wellness program. Your individually identifiable genetic or medical information will not be accessible to managers, supervisors, or others who make employment decisions for your spouse, or to anyone else in their workplace except as permitted by law. Your individually identifiable genetic or medical information will not be disclosed to Weir Group, PLC except in aggregate terms that do not disclose the identity of specific individuals. That aggregate information will be treated as a confidential medical record.
- Your information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted or required 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 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.

This Notice and Authorization does not restrict any rights you may have under the Americans with Disabilities Act or the Health Insurance Portability and Accountability Act (HIPAA). If the wellness program provides (directly, through reimbursement, or otherwise) medical care (including genetic counseling) the program may constitute a group health plan subject to HIPAA's privacy rules and you will receive a separate HIPAA privacy notice. If you have questions or concerns regarding this Notice and Authorization, or about protections against discrimination and retaliation, please contact HR Shared Services.

I, _____, (Spouse/domestic partner name) hereby acknowledge receipt of this Authorization and that I am knowingly and voluntarily authorizing Weir Group, PLC's wellness program to collect the genetic information specifically described herein.

_____ _____

Signature Date

No Surprises Act Notice

Your Rights and Protections Against Surprise Medical Bills
When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:
Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:
- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact U.S. Department of Health and Human Services. The federal phone number for information and complaints is: 1-800-985-3059. Visit **www.website.com** for more information about your rights under federal law.

IMPORTANT NOTICE

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% for 2026 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% for 2026 of the employee's household income.

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.

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. 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 **www.website.com** 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 HR Shared Services at 888-974-4727.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **www.website.com** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name: XX	4. Employer Identification Number (EIN): XXX	
5. Employer address: XXX	6. Employer phone number: XXX-XX-XX	
7. City: XX	8. State: XX	9. Zip code: XXXXX
3. Employer name: XX	4. Employer Identification Number (EIN): XXX	
10. Who can we contact about employee health coverage at this job? HR Shared Services		
11. Phone number (if different from above)	12. Email address:	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☒ All employees. Eligible employees are:
- Regular, full time and part time employees
- Seasonal and temporary employees
- Qualified dependents, including Domestic Partners meeting requirements and providing Domestic Partner Affidavit

☐ Some employees. Eligible employees are:

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:
- Your legal spouse/qualified domestic partner (same or opposite sex)
- Your child(ren) up to the age of 26 regardless of school or financial dependency status
- Your disabled child(ren) of any age and child(ren) a court requires you to cover, such as through a Qualified Medical Child Support Order (QMCSO)

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **www.website.com** will guide you through the process. Here's the employer information you'll enter when you visit **www.website.com** to find out if you can get a tax credit to lower your monthly premiums.

Summary of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Weir Group, PLC Health and Welfare Benefit Plan summary plan description (SPD). It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Machine-Readable File

The Transparency in Coverage Final Rules require certain group health plans to disclose on a public website information regarding in-network provider rates and historical out-of-network allowed amounts and billed charges for covered items and services in two separate machine-readable files (MRFs). The MRFs for the benefit package options under Weir Group, PLC Health and Welfare Benefit Plan are linked below:

www.website.com

This 2026 U.S. Benefit Guide is intended to be an overview of The Weir Group, PLC Welfare Benefit Plan, which provides you the opportunity to enroll in various benefit programs or options. Complete details about how the benefit programs/options work are included in the Summary Plan Description (SPD) and Plan Document. The Plan Document is available upon request and the SPD is located on the ADP forms library under Benefits. If there are any inconsistencies between this U.S. Benefits Guide and the Plan Document, the Plan Document will govern. Weir reserves the right to change or end the Plan and/or the benefit programs/options at any time. This Guide is not intended as a contract of employment or guarantee of current or future employment with Weir. Please retain this Guide for reference throughout the 2026 Benefits Plan Year - January 1 through December 31, 2026.