FLUENCE
A Siemens and AES Company

Fluence Energy U.S. Benefits Guide

2026 Plan Year

Benefits At A Glance

Brought to you in partnership with NFP An Aon Company

This is a high-level benefits guide of certain benefits your employer offers. The information in this booklet is intended as a general outline of the benefits offered under your Fluence benefits program and should not be considered legal, investment or other benefits advice. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail. Benefit plans are subject to change, amendment, or termination without notice to or the agreement of any employee/participant. All protected health information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

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BENEFITS OFFERED

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Our Benefit Period

JANUARY 1, 2026 – DECEMBER 31, 2026

BENEFITS THAT SUPPORT YOU

At Fluence, our employees are our most asset and we are therefore personally committed to ensuring you and your family stay healthy, feel secure and enjoy a positive work / life balance. Our Managers, HR Team, and senior leadership are equally dedicated to enabling our workforce to focus on supporting our customers, unhindered by concerns over the adequacy or reliability of their benefits.

To help us achieve these goals, we have worked hard to assemble a variety of effective and dependable benefit plans, backed by some of the industry's most reputable providers, as outlined in our benefits guide.

Our promise to you is that we will continue to refine and improve our benefits offerings, keeping pace with industry trends and innovations, and ultimately, to maximize their effectiveness and value for you – our most valued asset.

Helpful Tips To Consider Before You Enroll

1. **Do you plan to enroll an *eligible dependent(s)*?**
   If so, make sure to have their social security numbers and birthdates available. You cannot enroll your dependent(s) without this information.
2. **Have you recently been *married/divorced or had a baby*?**
   If so, remember to add or remove any dependent(s) and/or update your beneficiary designation.
3. **Did any of your covered children reach their 26th birthday *this year*?**
   If so, they may no longer be eligible for benefits, unless they meet specific criteria.

ELIGIBILITY
RULES | REQUIREMENTS

EMPLOYEE ELIGIBILITY

If you are a full-time permanent employee who has a regular schedule working a minimum of 30 hours per week, you are eligible for the Fluence benefits program effective on your date of hire. All enrollment forms must be turned into Human Resources no later than 30 days after your date of hire.

DEPENDENT ELIGIBILITY

You may also enroll eligible dependents for benefits coverage. A **'dependent'** is defined as the **legal spouse, domestic partner** and/or '**dependent child(ren)'** of the plan participant or the spouse/domestic partner.

The term 'child' refers to any of the following:

- A natural (biological) child;
- A stepchild;
- A legally adopted child;
- A foster child;
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse/domestic partner; or
- Disabled dependents may be eligible if requirements set by the plan are met.

The chart provided below explains who is eligible for coverage under each benefit plan type:

Line of Coverage	When coverage ends
Medical, Vision, Dental	The **last day of the month** the child turns **age 26**
Child Life Insurance	The **last day of the month** the child turns **age 26**

Qualifying Life Events

If you have a Qualifying Life Event and want to request a mid-year change, you must notify Human Resources and complete your election changes within 30 days following the event. Be prepared to provide documentation to support the Qualifying Life Event.

Common life events include: Birth, Marriage, Divorce, New Dependent, Loss/gain of available coverage by you or any of your dependents.

IMPORTANT

You cannot make changes to these elections during the year unless you experience a qualified family status change, which must be reported to Human Resources within 31 days of the event.

If you separate from employment, COBRA continuation of coverage may be available as applicable by law. COBRA Continuation details can be found in the notices section of this employee benefit guide.

HEALTH
MEDICAL | PRESCRIPTION DRUGS

COMMON INSURANCE TERMS

A **PREMIUM** is the amount you pay for insurance, using pre-tax or post-tax dollars.

A **COPAYMENT (COPAY)** is a fixed amount you pay to receive services. Your co-payment(s) will count towards your out-of-pocket maximum but not your deductible. (e.g., $25 for every visit to the doctor), while your insurance company pays the rest.

A **DEDUCTIBLE** is the amount of money you are responsible for paying each year before the plan begins to pay for covered services, with the exception of preventive care services, which are covered at 100% In-Network.

COINSURANCE This is your share of the expense of covered services after your deductible has been paid when the company plan is paying a percentage. The coinsurance rate is usually a percentage.

OUT-OF-POCKET (OOP) MAXIMUM is the most you pay per Plan Year for health care expenses and applies to deductibles, flat-dollar copays and coinsurance for all covered services – including cost-sharing amounts for prescription drugs.

Once this limit is met, the plan will cover all in-network services at 100% until the end of the plan year.

OUT-OF-NETWORK charges in the above plans are subject to reasonable and customary limitations, which means you are responsible for charges over this amount in addition to separate deductible and coinsurance. Any services received from an out-of-network provider, with the exception of a true emergency, will not be covered.

PPO | In-Network & Out-of-Network Benefits Available

The PPO option offers the freedom to see any provider when you need care. When you use providers from within the PPO network, you receive benefits at the discounted network cost. Most expenses, such as office visits, emergency room and prescription drugs are covered by a copay. Other expenses are subject to a deductible and coinsurance.

HDHP HSA | In-Network & Out-of-Network Benefits Available

The HDHP is similar to the PPO Plan in that you have the option to choose any provider when you need care. However, in exchange for a lower per-paycheck cost, you must satisfy a higher deductible that applies to almost all health care expenses, including those for prescription drugs.

All expenses are your responsibility until the deductible is reached, with the exception of preventive care, which is covered at 100% when you visit a physician in the network. Once the deductible is met, you are responsible for coinsurance for medical expenses and a copay for prescription drug expenses.

Enrolling in this plan allows you to contribute tax free dollars to a health savings account (HSA). Any dollars that you (and your employer) wish to contribute can be used towards any eligible medical, Rx, dental and vision expenses that you may incur while covered under the plan. See HSA section of this guide for additional details.

Did You Know?

- ✓ **Preventive Services** are **covered at 100% In-Network** and copays & deductibles do not apply.
- ✓ You **pay less** out of pocket if you receive care from an **In-Network provider.**

How do I find an In-Network Provider?

In-Network providers can be found on your provider's website (www.myuhc.com) under "Find Care & Costs".

OR

Search doctors at www.kp.org/searchdoctors

MEDICAL & PRESCRIPTION

HEALTH | PLAN COMPARISON

KAISER PERMANENTE®

IN-NETWORK BENEFITS	Kaiser CA HMO 20 Network
DEDUCTIBLE	
Single Deductible	$0
Family Deductible	$0
COINSURANCE *(applies after deductible is met)*	
Member Cost Share %	0%
Health Savings Account	
Eligible Plan for HSA	No
MEMBER COPAYMENT(S)	
Primary Care (PCP) - Office Visit	$20 copay
Specialist - Office Visit	$20 copay
Urgent Care Facility	$20 copay
Emergency Room Visit	$100 copay
PRESCRIPTION COPAYMENT(S) (RETAIL / MAIL ORDER)	
Generic	$10 / $30
Preferred Brands	$30 / $60
Non-Preferred Brands	$30 / $60
Specialty	20% coinsurance up to $150
OUT-OF-POCKET (OOP) MAXIMUM	
Single Maximum	$3,000
Family Maximum	$6,000

Your Care Options and When to Use Them.

Primary Care Physician (PCP)

For routine, primary/preventive care, or non-urgent treatment, we recommend going to your doctor's office for medical care. Your doctor knows you and your health history and has access to your medical records. You may also pay the least amount out-of-pocket when you receive care in your doctor's office.

Urgent Care Centers vs. Freestanding Emergency Rooms

Freestanding emergency rooms look a lot like the urgent care centers you are likely used to, but the costs and services are drastically different. In general, consider an urgent care center as an extension of your PCP, while freestanding emergency rooms should be used for health conditions that require a high level of care. Research the options in your area and determine which ones are covered by your insurance plan's network; note that balance billing may apply. Choosing an urgent care center instead of an emergency room for everyday health concerns could save you hundreds of dollars.

MEDICAL & PRESCRIPTION
HEALTH | PLAN COMPARISON

United Healthcare

IN-NETWORK BENEFITS	Choice Plus HSA Medium DZ4Y Network	Choice Plus HSA Medium DZ4Y Non-Network	Choice Plus HSA High DZ2W Network	Choice Plus HSA High DZ2W Non-Network
DEDUCTIBLE				
Single Deductible	$2,000	$4,000	$3,400	$6,600
Family Deductible	$4,000	$8,000	$6,800	$13,200
COINSURANCE *(applies after deductible is met)*				
Member Cost Share %	10%	30%	20%	40%
Health Savings Account				
Eligible Plan for HSA	Yes		Yes	
MEMBER COPAYMENT(S)				
Primary Care (PCP) - Office Visit	10% after ded.	30% after ded.	20% after ded.	40% after ded.
Specialist - Office Visit	10% after ded.	30% after ded.	20% after ded.	40% after ded.
Urgent Care Facility	10% after ded.	30% after ded.	20% after ded.	40% after ded.
Emergency Room Visit	10% after deductible		20% after ded.	
PRESCRIPTION COPAYMENT(S) (RETAIL / MAIL ORDER) *(applies after deductible is met)*				
Tier 1	$10		$10	
Tier 2	$50		$50	
Tier 3	$100		$100	
Specialty Tier 2 & 3 (No Mail Order)	$250		$250	
OUT-OF-POCKET (OOP) MAXIMUM				
Single Maximum	$4,000	$8,000	$6,000	$12,000
Family Maximum	$8,000	$16,000	$12,000	$24,000

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MEDICAL & PRESCRIPTION

HEALTH | PLAN COMPARISON

United Healthcare

Choice Plus PPO
DR3X

IN-NETWORK BENEFITS	Network	Non-Network
DEDUCTIBLE		
Single Deductible	$1,000	$2,000
Family Deductible	$2,000	$4,000
COINSURANCE *(applies after deductible is met)*		
Member Cost Share %	20%	40%
Health Savings Account		
Eligible Plan for HSA	No	
MEMBER COPAYMENT(S)		
Primary Care (PCP) - Office Visit	$35 copay	40% after ded.
Specialist - Office Visit	$60 copay	40% after ded.
Urgent Care Facility	$100 copay	40% after ded.
Emergency Room Visit	$350 copay	
PRESCRIPTION COPAYMENT(S) (RETAIL / MAIL ORDER)		
Tier 1	$10	
Tier 2	$50	
Tier 3	$100	
Specialty Tier 2 & 3 (No Mail Order)	$250	
OUT-OF-POCKET (OOP) MAXIMUM		
Single Maximum	$3,000	$6,000
Family Maximum	$6,000	$12,000

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ONLINE HEALTHCARE

24/7 | VIRTUAL DOCTOR VISITS

No crowded waiting rooms.
No Driving.
See a doctor when you need a doctor.

A virtual visit lets you see and talk to a doctor from your mobile device or computer. When you use one of the provider groups in our virtual visit network, you have benefit coverage for certain non-emergency medical conditions.
$0 Copay for Virtual Visits when seeing a UHC Provider Partner.

Optum

dr on demand

Teladoc HEALTH

amwell

Walmart Health Virtual Care

WHEN CAN I USE A VIRTUAL VISIT?

When you have a non-emergency condition and:

- your doctor is not available;
- you become ill while traveling;
- When you are considering visiting a hospital emergency room for a non-emergency health condition.

**Your covered children may also use Virtual Visits when a parent or legal guardian is present for the visit.*

Examples of Non-Emergency Conditions:

- ✓ Bladder infection
- ✓ Bronchitis
- ✓ Diarrhea
- ✓ Fever
- ✓ Pink eye
- ✓ Rash
- ✓ Seasonal flu
- ✓ Sinus
- ✓ Sore throat
- ✓ Stomach

HOW DOES IT WORK?

The first time you use a Virtual Visits provider, you will need to set up an account with that Virtual Visits provider group. You will need to complete the patient registration process to gather medical history, pharmacy preference, primary care physician contact information, and insurance information.

Each time you have a virtual visit, you will be asked some brief medical questions, including questions about your current medical concern. If appropriate, you will then be connected using secure live audio and video technology to a doctor licensed to deliver care in the state you are in at the time of your visit. You and the doctor will discuss your medical issue, and, if appropriate, the doctor may write a prescription* for you.

Virtual Visits doctors use e-prescribing to submit prescriptions to the pharmacy of your choice. Costs for the virtual visit and prescription drugs are based on, and payable under, your medical and pharmacy benefit. They are not covered as part of your Virtual Visits benefit.

**Prescription services may not be available in all states.*

HOW DO I GET ACCESS?

- ✓ Sign in or register at myuhc.com > Find a Doctor > Medical Directory > People > Virtual Care
- ✓ Or call the customer service number on the back of your ID card for assistance

FLEXIBLE SPENDING ACCOUNT

FSA | TAX SAVING VEHICLE

Flexible Spending Accounts (FSA) allow you to reduce your taxable income by setting aside pre-tax dollars from each paycheck to pay for eligible out-of-pocket health care and dependent care expenses* for yourself, your spouse and your dependent children.

In order to participate in the FSA, you must enroll each year. Your annual contribution stays in effect during the entire year **(January 1st through December 31st)**. The only time you can change your election is during the enrollment period or if you experience a change-in-status event. Also, you must elect this benefit within **31 days** of your hire date or first date of benefits eligibility.

ELIGIBLE EXPENSES

- A full list of qualified FSA expenses can be found in IRS Publication 502 at **www.irs.gov.**
- You can learn more about FSA qualified expenses and also make purchases by visiting the FSA Store at www.**fsastore.com.**

HEALTH CARE & LIMITED PURPOSE FSA

MAXIMUM ANNUAL CONTRIBUTION | $3,400

All eligible health care expenses – such as deductibles, medical and prescription copays, dental expenses, and vision expenses – can be reimbursed from your general-purpose FSA account.

With the Health Care FSA or Limited Purpose FSA, you can spend up to the full amount of your annual election as soon as your account has been set up.

LIMITED PURPOSE FSA | ADDITIONAL REQUIREMENTS

- If you open or contribute to a Health Saving Account (HSA), you may only enroll in a Limited Purpose FSA.
- If you enroll in a HDHP (High-Deductible Health Plan) and elect a Health FSA, you will automatically be enrolled in the Limited Purpose FSA.
- A limited purpose FSA will reimburse you for dental and vision expenses, but you cannot claim the same expense on both the FSA and HSA Accounts.

DEPENDENT CARE FSA

The Dependent Care FSA allows you to pay for eligible dependent care expenses with tax-free dollars so that you and your spouse can work or attend school FT.

Unlike the Health Care FSA, funds in a Dependent Care FSA are only available once they have been deposited into your account and you cannot use the funds ahead of time.

- You may set aside up to **$7,500** in pre-tax dollars in 2026, or **$3,750** if you are married and file taxes separately from your spouse.
- If you participate in a Dependent Care FSA, you cannot apply the same expenses for a dependent care tax credit when you file your income taxes.

IMPORTANT FSA RULES

- For 2026, the IRS annual salary reduction limit is $3,400.
- Note: If you have a health FSA you cannot contribute to an HSA in the same year unless you elect a “limited purpose” FSA.
- Estimate your predictable health expenses for 2026 (medical, dental, vision, prescriptions, anticipated treatments) and set your contribution accordingly.
- Remember the “use it or lose it” nature of the account – don’t contribute more than you expect to use.

*ELIGIBLE DEPENDENT CARE EXPENSES INCLUDE:

1. **‘Care’** for your dependent child who is under the age of 13 that you can claim as a dependent on your federal tax return;
2. **‘Care’** for your dependent child who resides with you and who is physically or mentally incapable of caring for themselves; or
3. **‘Care’** for your spouse, parent or grandparent who is physically or mentally incapable of caring for themselves and spends at least eight hours a day in your home.

‘Care’ is defined as: In-home baby-sitting services (not by an individual you claim as a dependent); care of a preschool child by a licensed nursery or day care provider; before and after-school care; summer day camp (provided it is not overnight); and in-home dependent day care.

HEALTH SAVINGS ACCOUNT

HSA | TAX SAVING VEHICLE

ENROLLED IN A HSA ELIGIBLE HEALTH PLAN?

Take charge of your health care spending with a Health Savings Account (HSA). Contributions to an HSA are tax-free, and no matter what, the money in the account is yours!

A Health Savings Account (HSA) is a tax-free savings account that is owned by you, is 100% vested from day one, and lets you build up savings for future needs. The funds may be used to pay for qualifying healthcare expenses not covered by insurance or any other plan for yourself, your spouse, or tax dependents. You decide how much you would like to contribute, when and how to spend the money on eligible expenses, and how to invest the balance.

UNDERSTANDING YOUR HSA

- Pre-tax contributions are deducted through payroll and deposited into your HSA account;
- You can use your HSA available funds to pay for qualified medical expenses tax-free;
- HSA funds can be used for non-eligible expenses but will be subject to regular income taxes and a 20% excise tax penalty.
- Unused funds remain in your account for future use and roll over each calendar year;
- HSAs remain with you even if you change health plans or companies. If you open an HSA and later become ineligible to make contributions, you can still use your remaining funds; and
- You can change your HSA contribution at any time during the plan year for any reason.

2026 | HSA FUNDING LIMITS

Each year, the IRS places a limit on the maximum amount that can be contributed to HSA accounts.

HSA Contribution Limits	
Employee	$4,400
Two Person/Family	$8,750

HSA "Catch-Up" Contributions	
Age 55 or older	$1,000 a year

Employer HSA Contribution (HSA High Plan Only)	
Employee	$1,000
Two Person/Family	$2,000

Your Maximum Contribution after employer contribution	
Employee	$2,400
Two Person/Family	$6,750

Source: IRS, Rev. Proc. 2020-30

HEALTH SAVINGS ACCOUNT

HSA | TAX SAVING VEHICLE

HSA ELIGIBILITY REQUIREMENTS

To have an HSA and make contributions to the account, you must meet several basic qualifications.

- ✓ To be eligible to open and contribute to an HSA, you must have coverage under a qualified High-Deductible Health Plan (HDHP).
- ✓ Participants cannot be covered by any other health insurance plan (this exclusion does not apply to certain other types of insurance, such as dental, vision, disability or long-term care coverage).
- ✓ Participants cannot participate in a Healthcare FSA or spouse/domestic partner's Healthcare FSA or Health Reimbursement Account (HRA).
- ✓ Participants cannot be enrolled in Medicare or Medicaid.
- ✓ You cannot be eligible to be claimed as a dependent on someone else's tax return.
- ✓ You have not received Department of Veterans Affairs Medical benefits in the past 90 days, unless the Veteran has a disability rating. (*There may be additional special circumstances, check with your tax preparer*).

MAINTAINING RECORDS

To protect yourself in the event that you are audited by the IRS, keep records of all HSA documentation and itemized receipts for at least if your income tax return is considered open (subject to an audit), or as long as you maintain the account, whichever is longer.

The IRS requires HSA funds to be used for qualified expenses only. If you use HSA funds for non-eligible expenses, you will be subject to regular income taxes and an additional 20% excise tax penalty.

ELIGIBLE HSA EXPENSES*

- Acupuncture
- Alcoholism treatment
- Ambulance
- Artificial limb
- Automobile modifications for a physically handicapped person
- Birth control pills
- Blood pressure monitoring device
- Braille books & magazines
- Chiropractic care
- Christian science practitioner
- COBRA premiums
- Contact lenses & related materials
- Crutches
- Dental treatment
- Dentures
- Diagnostic services
- Drug addiction treatment
- Eye examination
- Eye glasses & related materials
- Fertility treatment
- Flu shot
- Guide dog or other animal aide
- Hearing aids
- Hospital services
- Immunization
- Insulin
- Laboratory fees
- Laser eye surgery
- Long-term care premiums or expenses
- Medical testing device
- Nursing services
- Obstetrical expenses
- Organ transplant
- Orthodontia (not for cosmetic reasons)
- Oxygen
- Physical exam
- Physical therapy
- Prescription drugs
- Psychiatric care
- Retiree medical insurance premiums
- Smoking cessation program
- Surgery
- Transportation for medical care
- Weight loss program
- Wheelchairs and more*.

A full list of qualified expenses can be found in IRS Publication 502 at www.irs.gov.

DENTAL
COVERAGE OVERVIEW

COMMON TERMS

PRE-TREATMENT ESTIMATE
If your dental care is extensive and you want to plan ahead for the cost, you can ask your dentist to submit a pre-treatment estimate. While it is not a guarantee of payment, a pre-treatment estimate can help you predict your out-of-pocket costs.

DUAL COVERAGE
You might have benefits from more than one dental plan, which is called dual coverage. In this situation, the total amount paid by both plans can't exceed 100% of your dental expenses. And in some cases, depending on the specifics of the plans, your coverage may not total 100%.

LIMITATIONS AND EXCLUSIONS
Dental plans are intended to cover part of your dental expenses, so coverage may not extend to your every dental need. A typical plan has limitations such as the number of times you can receive a cleaning each year. In addition, some procedures may not be covered under your plan, which is referred to as an exclusion.

You have the freedom to select the dentist of your choice; however when you visit a participating in-network dentist, you will have lower out-of-pocket costs, no balance billing, and claims will be submitted

	High Plan	Low Plan
PLAN FEATURES	**Network / Non-Network***	**Network / Non-Network***
DEDUCTIBLE		
Single	**$50**	**$50**
Family	**$150**	**$150**
When does it apply?	When receiving Basic or Major services (Does not apply for Preventive or Orthodontia services)	
COVERED SERVICES		
CLASS I: Preventive Services *Routine exams & cleanings, x-rays, sealants, fluoride treatments & space maintainers*	**Covered at 100% / 100%**	**Covered at 100% / 100%**
CLASS II: Basic Services *Endodontics, periodontics, palliative care, fillings, oral surgery & general anesthesia*	**Covered at 90% / 90%**	**Covered at 80% / 80%**
CLASS III: Major Services *Prosthodontic repairs, crowns, inlays/onlays, dentures, bridges, & implants*	**Covered at 70% / 70%**	**Covered at 50% / 50%**
CLASS IV: Orthodontic Services For adults & children	**Covered at 50% / 50%**	**Not Covered**
ANNUAL MAXIMUM		
Maximum Benefit *Allowed per Benefit Period*	**$2,000 per covered individual**	**$1,000 per covered individual**
Orthodontia Maximum Benefit *Allowed per Lifetime*	**$1,500 per covered individual**	**N/A**

**Non-Network services can potentially be balance-billed.*

PREVENTION FIRST!
Your dental health is an important part of your overall health. Make sure you take advantage of your preventive dental visits.

Preventive care services are covered at 100% if you visit an In-Network provider. They are also not subject to the annual deductible.

How do I find an In-Network Provider?
This dental plan offers deeper discounts when you visit a provider that is In-Network. In-Network providers can be found on www.myCigna.com.

VISION
COVERAGE OVERVIEW

Under this plan, you may use the eye care professional of your choice. However, when you visit a participating in-network provider, you receive higher levels of coverage. If you choose to receive services from an out-of-network provider, you will be required to pay that provider at the time of service and submit a claim form for reimbursement.

	IN-NETWORK *Insight Network* PROVIDER	OUT-OF-NETWORK PROVIDER
PLAN FEATURES		
Vision Exam	**$10** copay	Up to **$40**
COVERED SERVICES – LENSES / FRAMES		
Single Lenses	**$25** copay	Up to **$30**
Bifocals	**$25** copay	Up to **$50**
Trifocals	**$25** copay	Up to **$70**
Frames	**$130** allowance	Up to **$65**
COVERED SERVICES		
Contact Lenses	$130 allowance	Up to **$65**
Contact Lens Evaluation Fitting	**Up to $40 copay**	Included in Exam Reimbursement
BENEFIT FREQUENCY		
Exams	Once every 12 Months	Once every 12 Months
Lenses	Once every 12 Months	Once every 12 Months
Frames	Once every 24 Months	Once every 24 Months
Contacts	Once every 12 Months *(contacts in lieu of frames/lenses)*	Once every 12 Months

Did you know your eyes can tell an eye care provider a lot about you?

In addition to eye disease, a routine eye exam can help detect signs of serious health conditions like diabetes and high cholesterol. This is important, since you won't always notice the symptoms yourself and since some of these diseases cause early and irreversible damage.

Need to locate a participating In-Network provider?

Visit www.eyemed.com, "Find an eye doctor".

Search by location, doctor name, or office name.

BASIC LIFE
COVERAGE OVERVIEW

BENEFICIARY(IES)

It's very important to designate beneficiaries. Taking a few minutes to designate your beneficiaries now will help ensure that your assets will be distributed according to your direction.

A Beneficiary is the person you designate to receive your life insurance benefits in the event of your death. It is important that your beneficiary designation is clear so there is no question as to your intentions.

It is also important that you name a **Primary** and **Contingent Beneficiary.** A contingent beneficiary will receive the benefits of your life insurance if the primary beneficiary cannot. You can change beneficiaries at any time.

You should review your beneficiary elections on a regular basis to ensure they are updated as life changes. Even if you are single, your beneficiary can use your Life Insurance to pay off your debts, such as: credit cards, mortgages, and other expenses.

**You designate your beneficiary(ies) when enrolling for your benefits.*

BASIC LIFE INSURANCE

Life insurance is an important part of your financial security. Life insurance helps protect your family from financial risk and sudden loss of income in the event of your death. AD&D insurance is equal to your Life benefit in the event of your death being a result of an accident and may also pay benefits for certain injuries sustained.

Company Paid Benefit - Provided to you at no cost	
Coverage Amount	**3x** your annual earnings up to **$250,000**
Accidental Death and Dismemberment (AD&D)	**3x** your annual earnings up to **$250,000**
Benefit Reduction Schedule	Your insurance will reduce to: – 65% of the original amount at age 65 – 50% of the original amount at age 70 – 35% of the original amount at age 75

ADDITIONAL PLAN PROVISIONS

Portability	If your employment ends or your retire, you may be eligible to continue your term insurance at group rates.
Conversion	When coverage ends under the plan, you can convert to an individual permanent life policy without evidence of insurability.

OTHER BASIC LIFE and AD&D FEATURES AND SERVICES

- Accelerated Benefit
- Life Services Toolkit
- Repatriation Benefits
- Standard Secure Access account payment option
- Travel Assistance
- Waiver of Premium
- Family Benefits Package
- Seat Belt and Air Bag Benefits

TheStandard®

WHAT WILL MY BENEFICIARY RECEIVE?

In The Event That Death Occurs:

- Your Basic Life insurance is paid to your beneficiary.
- **If death occurs from an accident:** 100% of the AD&D benefit would be payable to your beneficiary(ies) in addition to your Basic Life insurance.

SUPPLEMENTAL LIFE
COVERAGE OPTIONS FOR YOU & THE FAMILY

SUPPLEMENTAL LIFE INSURANCE

Employees have the opportunity to enroll in supplemental Life insurance. If you choose to enroll in employee coverage, this will be in addition to your employer provided Basic Life coverage. Coverage is also available for your spouse and/or child dependents. It is typically required that you elect coverage for yourself in order to be eligible for coverage on your dependents.

PLAN OPTIONS			
Cost of Coverage	Premiums are based on age-rated tables and paid by the employee every pay period through a payroll deduction. These premiums are post-tax and benefits payable are tax-free.		
Coverage Options	**Employee Coverage** Choose in $10,000 increments up to the lesser of 6x your annual salary or $300,000	**Spouse Coverage** Choose in $5,000 increments up to the lesser of 100% of the amount you elect for yourself or $300,000	**Dependent Coverage** Choose in $2,000 increments up to $10,000
Do I have to take a health exam to get coverage?	If you and your dependents enroll in coverage at your initial eligibility date, you may apply for up to the Guaranteed Issue amounts without medical questions.		
Guaranteed Issue	**Employee** $50,000	**Spouse** $15,000	**Dependent** $10,000

PLAN PROVISIONS		
Cost Calculation	Age Rated Benefit (Spouse Life based on employee's age)	
Benefit Reduction Schedule	**Employee Coverage Will Reduce To:** – 65% of the original amount at age 65 – 50% of the original amount at age 70 – 35% of the original amount at age 75	**Spouse Coverage Will Reduce By:** The same amount and at the same time your coverage reduces
Portability	If your employment ends or you retire, you may be eligible to continue your term insurance at group rates.	
Conversion	When coverage ends under the plan, you can convert to an individual permanent life policy without evidence of insurability.	

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*Guaranteed Issue (GI) and Evidence of Insurability (EOI)

When you are first eligible (at hire) for Voluntary Life and AD&D, you may purchase up to the Guaranteed Issue (GI) for yourself and your spouse without providing proof of good health (EOI). Annually, you are able to increase elections 2 increment up to GI without proof of good health.

Any amount elected over the GI will require EOI. If you elect optional life coverage, and are required to complete an EOI, it is your responsibility to complete the EOI and send to the provider (address will be listed on your form). In addition, your spouse will need to provide EOI to be eligible for coverage amounts over GI – or – if coverage is requested at a later date.

DISABILITY

SHORT-TERM | LONG-TERM

SHORT-TERM DISABILITY (STD)

Everyday illnesses or injuries can interfere with your ability to work. Even a few weeks away from work can make it difficult to manage household costs.

Short Term Disability coverage provides financial protection for you by paying a portion of your income, so you can focus on getting better and worry less about keeping up with your bills.

LONG-TERM DISABILITY (LTD)

Serious illnesses or accidents can come out of nowhere. They can interrupt your life, and your ability to work for months – even years.

Long Term Disability provides financial protection for you by paying a portion of your income, so you have financial support to manage your disability and your household.

PLAN FEATURES	SHORT-TERM DISABILITY (STD)	LONG-TERM DISABILITY (LTD)
Cost of Coverage	**This benefit is paid for by Fluence Energy.**	**This benefit is paid for my Fluence Energy.**
Elimination Period *This is the number of days that must pass between your first day of a covered disability & the day you can begin to receive your disability benefits.*	Benefits begin on the **7th day of an accident** and the **7th day of an illness (including pregnancy)**	Your elimination period is **180 days** (if elected, this will be the benefit duration of Short Term Disability)
Benefit Duration *The maximum number of weeks you can receive benefits while you are sick or disabled.*	**Payments may last up to 180 days** You must be sick or disabled for the duration of the waiting period before you can receive a benefit payment.	**Payments will last for as long as you are disabled, or until you reach the Social Security Normal Retirement Age (SSNRA)** You must be sick or disabled for the duration of the elimination period before you can receive a benefit payment.
Coverage Amount	Covers **66.67% of your weekly income,** up to a maximum benefit of **$2,500 per week.**	Covers **66.67% of your monthly income,** up to a maximum benefit of **$13,750 per month.**
What's covered?	**A variety of conditions and injuries.** Typical claims would include: pregnancy, injuries, joint, back and digestive disorders.	**A variety of conditions and injuries.** Typical claims would include: cancer, back disorders, injuries and poison, cardiovascular, joint disorders.
ADDITIONAL PLAN PROVISIONS		
Benefit Payment Frequency	**Weekly benefit** may be reduced or offset by other sources of income.	**Monthly benefit** may be reduced or offset by other sources of income.
Waiver of Premium	If you're disabled and receiving benefit payments, you cost may be waived until you return to work.	If you're disabled and receiving benefit payments, you cost may be waived until you return to work.

EMPLOYEE ASSISTANCE PROGRAM

As an added benefit, The Standard provides an employee assistance plan at no cost to you. You and members of your household are entitled to up to 3 face-to-face consultations with a licensed clinician each year.

Your EAP covers a broad range of issues:

- Health & wellness concerns
- Stress and anxiety
- Relationship and family problems
- Referral services for elder and child day care
- Financial and legal concerns….and so much more!

How do I get help?

Call Health Advocate 888.293.6948

or visit the online portal http://www.healthadvocate.com/Standard3

TRAVEL ASSISTANCE PLAN

Employees have free access to Travel Assistance. This value-added service is provided through The Standard. Coverage is available when you travel 100 miles or more away from home. Services include pre-trip and cultural information, lost or stolen documents assistance, language translation services, medical evacuation / transportation and more!

Under the medical evacuation, The Standard will arrange and pay for the transportation of the patient to the nearest medical facility able to treat the illness or injury. Once the patient is able to travel home, The Standard will arrange and pay for the trip. Transportation for your dependents will be available if the medical emergency leaves no parent available.

Call 800-527-0218 within the U.S. or 410.453-6330 if outside the U.S.

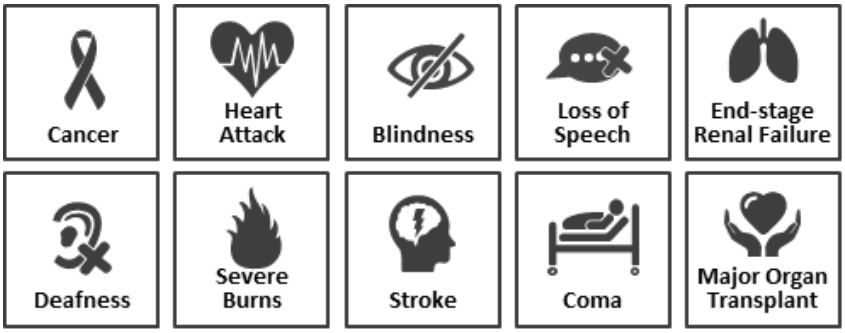
VOLUNTARY BENEFITS
CRITICAL ILLNESS

Critical Illness Insurance

How would you pay your bills if you were suddenly diagnosed with cancer and couldn't work? Critical illness insurance doesn't' pay your medical bills. It pays you if you're diagnosed with a covered illness. The benefit is paid directly to you, and it is your choice how to spend it.

What's Covered?

Critical illness can vary widely from one another. Some may focus on a single specific diagnosis, while others may provide you with coverage for a range of possible diagnoses, such as:



COVERAGE OPTIONS	**Employee Coverage** Choose up to $30,000 in $10,000 increments	**Spouse Coverage** Choose up to $15,000 in $5,000 increments	**Dependent Coverage** Automatically covered at 50% of your coverage amount

$50 WELLNESS BENEFIT Per Covered Individual

For Screenings such as: Colonoscopies, Mammograms, mental health assessments and other tests listed in your policy.

SUPPLEMENTAL BENEFITS
EAP | LEGAL RESOURCES

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Fluence realizes that your needs go beyond just the standard insurance. This is why we also provide all employees and their families with access to personal service and assistance resources at no cost. Here you will find information on our Employee Assistance Program and Travel Assistance resources, both to give you peace of mind and support when you need it the most!

Employee Assistance Program | 1-800-424-4039|
Member.magellanhealthcare.com

When it comes to balancing family, work and personal needs, your Employee Assistance Program, administered by Magellan Healthcare, can help you with everything from checking off daily tasks to working on more complex issues.

Key features

- No cost to you and your household members
- Completely confidential service provided by a third party
- Available 24/7/365

Services to help you with your moments of life:

- ***Counseling***—counselors provide support on issues such as anxiety, stress, depression, relationships, substance misuse and more. Counseling is available in-person, by text message, live chat, phone or video conference.
- ***Digital emotional wellness tools***—self-guided programs for mental health, grief and loss, resilience, conflict management, chronic pain and more.
- ***Lifestyle coaching***—define and achieve your goals with the support of a coach including help with personal improvement, healthy eating, weight loss and more.
- ***Financial wellness, Legal services and Identity theft resolution***—get expert help to take control of your finances, resolve legal issues, restore credit, research specific topics and/or print your own state-specific legal forms.
- ***Work-Life web services***—receive online help in the form of webinars, live talks and articles important life events and everyday challenges for parents and seniors such as child and elder care, education, parenting and more.
- ***Discount center***—access hundreds of deals on nationally recognized brand-name products and services, all in one convenient place. Find discounts on consumer goods, travel, child and elder care, fitness centers, movie tickets and more.

LEGAL RESOURCES

Legal Resources is a voluntary Employee benefit plan that provides a wide array of legal services for employees and their dependents. Most needed services are covered at 100%, meaning you don't pay any attorney fees. Anything not fully covered, (more complex legal matters), is covered at a 25% discount. Should you enroll in this plan, you are required to stay on the plan for a minimum of 12 months and are not able to exit the plan until the following open enrollment.

Example of services covered at 100%:

- Family Law
- Traffic Violations (DUI Included)
- Wills, Trusts and Estate Matters
- Criminal Matters
- Divorce and Child Custody
- Real Estate Matters
- Billing Disputes
- Courtroom Representation

Highlights:

- The cost is **$20.00** per month and covers you, your spouse, and eligible dependents.
- Unlimited usage, no deductible, co-pays, or claim forms.
- You select your own full service local law firm and call your attorney directly when legal needs arise.
- Over 14,000 attorneys nationwide provide legal services for needs outside of the local law firm network.
- Pre-existing legal matters are covered at a 25% discount.
- Customer Service is Provided by Licensed Paralegals: 800-728-5768

How the Plan Works:

- Choose a law firm that best suits your needs from a highly rated law firm network.
- Call your law firm for any advice, consultation, and representation.

METLIFE PET INSURANCE

We know you care about your pets and MetLife can help you support your furry family.

- Flexibility to select various levels of coverage with no breed exclusions or upper age limits; ability to include multiple pets on one policy through our innovative family plans
- Optional wellness coverage (preventive care) included in annual limit to cover flea and tick medications, teeth cleaning, blood work and more
- Competitive rates with discounts,14 and the only provider offering family plans15(i.e., multiple pets covered by one policy)
- Healthy pet incentive16 where employee's deductible decreases for each year without a claim
- Team of pet advocates to assist with enrollment & service, access to 24/7 live vet chat

PARKING AND TRANSIT ACCOUNT

PARKING AND TRANSIT ACCOUNT

This program allows you to set aside money from your paycheck on a tax-fee basis each month. You may then reimburse yourself from your account during the year for eligible work-related parking and work-related mass transit expenses.

Because of the tax savings this benefit provides, the IRS places certain limits and rules on how it may be used. If you do not use all of the money in your account during the plan year, you forfeit the money – so you must plan carefully.

WHAT ARE THE BENEFITS?

- You pay fewer taxes
- You increase your spendable income
- Not subject to ERISA, Cafeteria Plan rules
- Monthly limits
- Ability to adjust or revoke your elections monthly
- Amounts carry over from month to month

PARKING RULES

- Parking must be at or near workplace or commuting location
- Employee use only
- Not available for temporary work locations
- If payments are monthly, need not prorate for days missed

2026 MONTHLY LIMITS

- TRANSIT PASS: $340
- PARKING: $340

PLEASE NOTE:

We encourage you to review and consider the Transportation FSA, with its tax favored options, for your transportation needs.

Your FSA card cannot be used for DC Metro. For DC Metro, expenses must be submitted to Voya for reimbursement.

EMPLOYEE CONTRIBUTIONS

UNITED HEALTHCARE MEDICAL PLAN COST

ChoicePlus PPO (DR3X)	Monthly Cost
Employee	$272.16
Employee + Child(ren)	$468.11
Employee + Spouse	$571.53
Family	$821.93
Choice Plus Medium HSA (DZ4Y)	**Monthly Cost**
Employee	$118.46
Employee + Child(ren)	$191.02
Employee + Spouse	$233.23
Family	$357.76
ChoicePlus High HSA (DZ2W)	**Monthly Cost**
Employee	$75.99
Employee + Child(ren)	$123.57
Employee + Spouse	$151.58
Family	$235.28

KAISER OF CALIFORNIA MEDICAL PLAN COST

HMO Plan	Monthly Cost
Employee	$169.57
Employee + Child(ren)	$291.66
Employee + Spouse	$356.09
Family	$512.09

EMPLOYEE CONTRIBUTIONS

CIGNA DENTAL PLAN COST

Low Dental Plan	Low Plan Monthly Cost
Employee	$14.75
Employee + Child(ren)	$30.68
Employee + Spouse	$32.16
Family	$51.31

High Dental Plan	High Plan Monthly Cost
Employee	$24.85
Employee + Child(ren)	$51.92
Employee + Spouse	$55.58
Family	$88.33

EYEMED VISION PLAN COST

Vision Plan	Monthly Cost
Employee	$3.12
Employee + Child(ren)	$5.51
Employee + Spouse	$6.27
Family	$8.66

GLOSSARY OF TERMS

Dependent Verification Services (DVS) – Service used to verify dependent proof of relationship when adding dependents to benefit plans.

Beneficiary – A person designated by you, the participant of a benefit plan, to receive the benefits of the plan in the event of the participant's death.

- **Primary Beneficiary –** A person who is designated to receive the benefits of a benefit plan in the event of the participant's death
- **Contingent Beneficiary** – A person who is designated to receive the benefits of a benefit plan in the event of the Primary Beneficiary's death

Charges – The term "charges" means the actual billed charges. It also means an amount negotiated by a provider, directly or indirectly, if that amount is different from the actual billed charges.

Coinsurance (coins) – The percentage of charges for covered expenses that an insured person is required to pay under the plan (separate from copayments)

Deductible (DED) – The amount of money you must pay each year to cover eligible expenses before your insurance policy starts paying.

Dependents – Dependents are your:

- Lawful spouse through a marriage that is lawfully recognized.
- Domestic partner (same or opposite sex)
- Dependent child(ren) (married or unmarried) under the age of 26 including stepchildren and legally adopted children.

Proof of relationship documentation will be required in order to add dependents to your plan(s). Employees will receive request for documentation.

Emergency Services – Medical, psychiatric, surgical, hospital, and related health care services and testing, including ambulance service, that are required to treat a sudden, unexpected onset of a bodily injury or serious sickness that could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life, or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones.

The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital, or the final diagnosis – whichever reasonably indicated an emergency medical condition – will be the basis for the determination of coverage provided such symptoms reasonably indicate an emergency.

Evidence of Insurability (EOI) – Proof that you are insurable based on the requirements of the insurance carrier. *For example, the results of a blood test or a doctor's signature on a form may be required for you to be covered by/for Optional Life insurance.*

Explanation of Benefits — The health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs are your responsibility.

Health Reimbursement Account (HRA) – The Health Reimbursement Account (HRA) is an employer-funded account that reimburses you for eligible out-of-pocket medical expenses. The HRA is only available to employees who are enrolled in the HRA Plan.

In-Network – The term "in-network" refers to health care services or items provided by your Primary Care Physician (PCP) or services/items provided by another participating provider and authorized by your PCP or the review organization. Authorization by your PCP or the review organization is not required in the case of mental health and substance abuse treatment other than hospital confinement solely for detoxification.

Emergency Care that meets the definition of "emergency services" and is authorized as such by either the PCP or the review organization is considered in-network.

Out-of-Network - The term "out-of-network" refers to care that does not qualify as in-network.

Maximum Out of Pocket — The most money you will pay during a year for coverage. It includes deductibles, copayments and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.

Medically Necessary/Medical Necessity – Required to diagnose or treat an illness, injury, disease, or its symptoms; in accordance with generally accepted standards of medical practice; clinically appropriate in terms of type, frequency, extent, site, and duration; not primarily for the convenience of the patient, physician, or other health care provider; and rendered in the least intensive setting that is appropriate for the delivery of the services and supplies.

Participating Provider – A hospital, physician, or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services with regard to a particular plan under which the participant is covered.

Post-Tax – An option to have the payment to your benefits deducted from your gross pay after your taxes have been withheld. Therefore, your tax contributions will be calculated based on a higher amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a higher amount.

Pre-Tax – An option to have the payment to your benefits deducted from your gross pay before your taxes have been withheld. Therefore, your tax contributions will be calculated based on a lesser amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a lesser amount.

Primary Care Dentist (PCD) – The term "Primary Care Dentist" means a dentist who (a) qualifies as a participating provider in general practice, referrals, or specialized care; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for dental care for you or any of your insured dependents.

Primary Care Physician (PCP) – The term "Primary Care Physician" means a physician who (a) qualifies as a participating provider in general practice, obstetrics/gynecology, internal medicine, family practice, or pediatrics; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for medical care for you or any of your insured dependents.

Proof of Relationship Documentation – Documents that show a dependent is lawfully your dependent. Documents can include marriage certificates, birth certificates, adoption agreements, previous years' tax returns, court orders, and/or divorce decrees showing your or your spouse's responsibility for the dependent.

IMPORTANT CONTACT INFORMATION

PROVIDER	CONTACT INFORMATION
United Healthcare Medical	(877) 844-4999 www.myuhc.com
Kaiser (CA Employees) Medical	(800) 514-0985 www.kp.org
Cigna Dental	(800) CIGNA24 www.myCigna.com
EyeMed Vision	(866) 939-3633 www.eyemedvisioncare.com
The Standard Life / STD & LTD / Voluntary Life	(888) 937-4783 www.Standard.com
Voya FSA / Dependent Care / HSA	(833) 232-4673 www.voyasupport@voya.benstrat.com
Voya Parking / Transit	(833) 232-4673 www.voyasupport@voya.benstrat.com
Magellan Employee Assistance Plan	(800) 424-4039 www.member.magellanhealthcare.com
Legal Resources Voluntary Legal Plan	(800) 728-5768 www.legalresources.com
MetLife Voluntary Pet Insurance	(866) 712-0255 metlife.com/getpetquote
T. Rowe Price Fluence Savings Plan	(800) 354-2351 www.troweprice.com
ADP Benefit Enrollment Website	(855) 547-8508 www.login.adp.com

Have Questions?

Please see the chart below for provider customer service phone numbers and website addresses.