U.S. EMPLOYEE BENEFITS GUIDE

2027





You power the future.
Benefits that power you.

EnerSys®
Power/Full Solutions

www.enersys.com



“At EnerSys, our people are at the center of everything we accomplish. Our benefits are designed to support you and your family with resources that contribute to your health, financial well-being and life beyond work. I encourage you to take time to explore this guide, understand the options available to you and make the choices that best fit your needs.

Thank you for everything you bring to EnerSys and for being part of our team.”

Todd Sechrist
Chief People Officer



BENEFITS CONTACT LIST

Enrollment and Support

Benefits Administration
Administrator: Benefit Solver
Company Key: enersys
Support Center: 855-849-4241
Website: **www.benefitsolver.com**

HR Shared Services
Phone: 833-305-4090
Email address: **hr_help@enersys.com**

This Benefits Guide has been developed to provide information about the EnerSys Benefits Program and help you consider important factors while evaluating your benefit options. Every effort has been made to ensure the information contained in this guide is correct. However, where discrepancies exist between this document and the Plan Document, the Plan Document will prevail. All Plan Documents can be found in the Reference Center once logged into your www.benefitsolver.com account.

Health

Medical
Provider: Highmark Blue Shield
Group# E5M378 (Preferred-Care Blue)
Group# E6S378 (PPO Blue)
Customer Service: 833-227-9379
Website: **myhighmark.com**

Prescription
Provider: Navitus
Rx BIN #: 610602
PCN #: NVT
Group#: ESY
Customer Service: 844-268-9789
Website: **www.navitus.com**

Top Provider Reimbursement Program
Provider: Garner
Customer Service: 866-761-9586
Website: **www.getgarner.com**
Learn more: **www.garnerguide.com/enersys**

Health Condition Management
Provider: Teladoc
Customer Service: 1-800-TELADOC
Website: **Teladochealth.com/go/ENERSYS**

Telemedicine
Provider: Well360 Virtual Health
Customer Service: 866-883-7358
Website: **myhighmark.com**

Voluntary Benefits
Provider: Voya
Group Name: EnerSys, Inc.
Group# 731307
Customer Service: 877 236-7564
Website: **https://presents.Voya.com/EBRC/EnerSys**

Health Savings Accounts& Flexible Spending Accounts
Provider: Empower
Customer Service: 855-375-3050
Website:
www.empowermyretirement.com

Dental
Provider: Delta Dental
Group Number: 2859
Customer Service: 800-932-0783
Website: **www.deltadentalins.com**

Vision
Provider: VSP
Group Number: 12194991
Customer Service: 800-877-7195
Website: **www.vsp.com**

Welfare

Short Term Disability
Administrator: Telus Health
Customer Service: 833-844-5807
Website:
www.enersys.absence.telushealth.com

Long Term Disability
Provider: Prudential
Control Number: 72693
Customer Service: 800-842-1718
Website: **mybenefits.prudential.com**

Life Insurance
Provider: Prudential
Customer Service: 800-524-0542
Website: **mybenefits.prudential.com**

Retirement

401(k)
Provider: Empower
ID Number: Employee ID
Customer Service: 844-465-4455
Website: **www.empowermyretirement.com**

Other

Identity Theft Protection
Provider: ID Watchdog
Customer Service: 866-513-1518
Website:
https://dashboard.idwatchdog.com/

Employee Assistance Program
Provider: Spring Health
Customer Service: 844-931-4465
Website: **www.myhighmark.com**

Employee Discount Program
Provider: PerkSpot
Customer Service: 866-606-6057
Website: **enersys.perkspot.com**

Travel Assistance Program
Business Travel
Provider: Chubb
Customer Service (US or Canada): 800-243-6124
Customer Service (outside of US): 202-659-7803

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GENERAL BENEFITS INFO

Employee Eligibility

Employees eligible to participate in the EnerSys Benefits Program are those employees who are US residents, classified as full time, and who regularly work more than 30 hours per week.

Dependent Eligibility

Below is a list of dependents who may be covered by the EnerSys Benefits Program.

- Legal Spouse (or Common-Law Spouse where recognized)
- Same or opposite sex Domestic Partner
- Natural, step, or adopted children, up to age 26
- Disabled dependent children of any age
- Children of Domestic Partners (Domestic Partner must be enrolled to cover children of Domestic Partner)
- Children in the process of being legally adopted (if there is a legal obligation for support)
- Children covered under a Qualified Medical Child Support Order who are under the age of 26

Dependent Verification

Proof of a dependent relationship is required to cover newly added dependents. Failure to submit the appropriate documentation by the specified deadline will disqualify your dependent(s) from coverage.

Required documentation:

- Legal Spouse – marriage certificate
- Common-Law Spouse – state-specific issued document
- Domestic Partner
- Notarized Domestic Partner Affidavit
- Proof of shared residency
- Proof of financial interdependence
- Children – Birth Certificate



How to Submit Verification

To supply the required documentation, scan and upload to www.benefitsolver.com by clicking on My Tasks near the top of the page or select your name in the top-right corner and choose Profile>Your Dependents. If you have submitted supporting documentation to Benefit Solver in the past, you will not have to resubmit documentation unless you receive notification you are subject to a dependent audit.

GENERAL BENEFITS INFORMATION

Qualifying Life Events (QLE)

Because of the favorable tax treatment, plan participants are only permitted to make changes to pre-tax benefits annually during Open Enrollment or in the event of a Qualifying Life Event. A few examples of a Qualifying Life Event include:

- Marriage/Divorce
- Birth/Adoption
- Death of a covered dependent
- Change in employment status
- Gaining or losing coverage through a spouse
- Becoming eligible for Medicare or Medicaid

Changes to benefit elections due to Qualifying Life Events must be completed and substantiated with the Benefit Service Center within 30 days of the event (60 days in the event of birth or adoption). If not completed by this deadline, changes to benefits cannot be made until the next Open Enrollment.

Paying For Benefits

Premiums for optional benefits are deducted from each paycheck on a pre-tax or a post-tax basis. Pre-tax benefits are deducted from your paycheck before any payroll tax is taken. Medical, Dental, Vision and Savings/Spending Account elections are paid on a pre-tax basis. This allows your taxable income to be reduced before taxes are taken allowing you to realize tax savings. Post-tax benefits are taken after all payroll taxes are taken. Employee Paid Life Insurance, Long Term Disability, Voluntary Benefits, and ID Theft Protection elections are paid on a post-tax basis. Because these benefits are paid for with post-tax dollars, any benefit payments made to you are made on a post-tax basis.

If you are on an unpaid leave of absence and premium deductions cannot be withheld from your paycheck, it is your responsibility to make payment through the Benefitsolver website. Benefits may be terminated for non-payment retroactively to the first missed payment if payment is not received by the end of the grace period following the due date. Please call Benefitsolver directly for payment support relating to a past due amount.

Initial Enrollment

New hires or newly eligible employees must make their benefit elections within their first 45 days of employment or eligibility. Benefits become effective the 31st day in an eligible position. If you do not make elections during your Initial Enrollment window, you will only be able to elect benefits during a future Open Enrollment unless you experience a Qualifying Life Event. Benefits elected during Open Enrollment become effective on the first day of the following calendar year.

Termination of Benefits

If your employment or benefit eligibility ends, your medical, dental and vision coverage will end on the last day of the month in which this event takes place.

Dependent Age Out

Dependent Children will be ineligible to participate in the EnerSys Health and Welfare plan as of their 26th birthday. Any benefit in which your dependent child was enrolled on their 26th birthday will be terminated the last day of the calendar month in which they turn 26.





ENROLLMENT INSTRUCTIONS

EnerSys utilizes Benefitsolver to administer the enrollment process. If at any point during the enrollment process you have questions about a benefit, if you need help navigating the online enrollment platform, or if you would prefer to enroll by phone, experienced customer service representatives are available to take your call Monday-Friday from 9:00am-6:00pm Eastern Standard Time. The EnerSys dedicated Benefitsolver Support Center phone number is 855-849-4241.

First Time Users of Benefitsolver

1) Log onto www.benefitsolver.com.
2) Select register under I am a first-time user.
3) Enter your social security number, date of birth, and the company key: enersys (case sensitive).
4) Create your username and password.
5) Click the Start Here button to begin your enrollment session

Established Users of Benefitsolver

1) Log onto www.benefitsolver.com.
2) Enter your username and password.
3) Click the Start Here button to begin your enrollment session

Download the Benefitsolver MyChoice mobile app from the App Store or Google Play. Use the app to:

- Participate in Open Enrollment
- Make Life Event changes year round
- Review plan documents and details
- Upload pictures of documents
- Receive Support
- Get most up to date benefits info

MEDICAL INSURANCE

EnerSys provides access to two medical options in an effort to best meet the needs of you and your family: the PPO Plan and the High Deductible Plan or HDP Plan.

EnerSys partners with Highmark Blue Shield to provide discounted services with certain hospitals, physicians and other health care providers, which are called Network Providers. Network Providers have agreed to charge reduced fees to participants of the EnerSys Medical Plan. Because of this, plan participants will incur lower out-of-pocket expense when utilizing a Network Provider.

It is always the participant's choice to decide which provider to use. If a Network Provider is used, plan participants should show their ID card to the provider.

It is always the participant's choice to decide which provider to use. If a Network Provider is used, plan participants should show their ID card to the provider. The provider will submit a claim for benefits directly to Highmark Blue Shield. Benefit payments are then made directly to the Network Provider (applicable copay or coinsurance may apply). If a non-network provider is used, plan participants may be required to pay for services at the time the service is rendered. Plan participants would then need to submit their claim to Highmark Blue Shield for reimbursement.

To assist you in locating providers in your area, use the Find a Doctor feature on the Highmark Blue Shield website at myhighmark.com or contact Highmark Blue Shield at 833-227-9379.

SERVICES	PPO PLAN		HDP PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	$800 individual $1,900 family	$1,600 Individual $3,800 Family	$2,600 Individual $5,200 Family	$5,200 Individual $10,400 Family
Out-of-Pocket Limit	$3,750 Individual $7,750 Family	$7,500 Individual $15,500 Family	$5,500 Individual $10,000 Family	$11,000 Individual $22,000 Family
Coinsurance	20%	40%	20%	40%
BASICS				
Virtual Care (medical)	$0 copay	Not Covered	0%	Not Covered
Office Visit	$25 copay	40%	20%	40%
Specialist Visit	$40 copay	40%	20%	40%
Urgent Care	20%	20%	20%	20%
Emergency Room	$200 copay then 20% after deductible *(copay waived if admitted)*		20%	20%
INPATIENT SERVICES				
Physician/Surgeon	20%	40%	20%	40%
Facility Fees	20%	40%	20%	40%
Diagnostic (X-Ray & Lab)	20%	40%	20%	40%
Mental Health Services	20%	40%	20%	40%
Substance Abuse	20%	40%	20%	40%
Pregnancy	20%	40%	20%	40%
OUTPATIENT SERVICES				
Physician/Surgeon	20%	40%	20%	40%
Facility Fees	20%	40%	20%	40%
Diagnostic (Imaging & Lab) – Outpatient	20%	40%	20%	40%
Diagnostic (Imaging & Lab) – Free-Standing Facility/Independent Lab	0%; no deductible	40%	N/A	N/A
Mental Health Services	20%	40%	20%	40%
Substance Abuse	$25 copay	40%	20%	40%
Pregnancy	$40 copay	40%	20%	40%

MyHighmark

Whether on your phone or your laptop, MyHighmark brings together everything you need to manage your health – all in one place. With MyHighmark, you can:

- Access your virtual member ID Card.
- Find in-network healthcare providers in your area or in an area to which you plan to travel.
- Access the Spring Health Employee Assistance Program.
- Access virtual physical and mental health care using Well360 Virtual Health.
- View recent claims, deductible and out-of-pocket accumulators, and manage your costs.
- Get access to information about the Highmark 24/7 Nurseline, exclusive member discounts, maternity resources, case management, advanced care planning, worldwide benefits and much more.
- Receive personalized recommendations for health programs.
- Find virtual health tools and activities to help you reach your goals.

Freestanding Lab & Imaging Centers

Did you know that you have a choice in where you can have lab/ blood work or radiology (i.e. x-ray, MRI, CT Scan, etc.) services performed? By going to a freestanding lab or imaging center, you can experience cost savings. For those enrolled in the PPO Plan, you will have no out-of-pocket costs when using a freestanding location. For those in the HDP, you will pay less out-of-pocket expenses (deductible and coinsurance) at a freestanding location versus going to a hospital for services. To find an eligible lower cost provider in your area, you can search for Freestanding Labs or Freestanding Radiology on the member website or call a customer advocate for assistance at 1-833-227-9379.

Healthcare When Traveling Abroad

As a Highmark member, you may have the ability to take your health care benefits with you when you travel outside of the United States. Through the Blue Cross Blue Shield Global Core program, you have access to health care resources around the world.

To take advantage of the program:

- Always carry your current Highmark member ID card. Download the BCBS Global Core program app for Apple or Android devices for convenient access to support tools and resources.
- Before you go, contact Member Services at the number on the back of your Highmark member ID card for benefit and coverage details.
- If you need to locate a doctor or hospital, you can search for providers at bcbsglobalcore.com or call the BCBS Global Core Service Center at 1-800-810-BLUE (2583).
- If you need inpatient care, call the BCBS Global Core Service Center to arrange direct billing. In most cases, you won't need to pay upfront for inpatient care except for
- out-of-pocket expenses (non-covered services, deductible, copayment, and coinsurance).
- In addition to contacting the BCBS Global Core Service Center, call Highmark Member Services at 833-227-9379 for inpatient authorizations. This number can also be found on the back of your Highmark Medical ID Card.
- If direct payment hasn't been arranged, you may need to pay upfront and submit a claim for reimbursement. Complete and submit a BCBS Global Core international claim form or submit your claim online at bcbsglobalcore.com or through the BCBS Global Core mobile app.

Based on your plan, exclusions may apply, and coverage may differ (copays, deductibles, coinsurance, etc.).





THE PREVENTIVE INCENTIVE PLAN

Preventive Care

Preventive Care is designed to prevent, detect, and treat illness at early stages. As a medical plan participant, you and any dependent covered by the EnerSys Medical Plan are able to schedule and complete your annual Preventive Care Exam with your Primary Care Physician every year at no cost. The exam is always covered by the plan at 100% (recommended lab or other testing may be subject to deductible and coinsurance).

Remember, as a medical plan participant, you also have access to preventive screenings/services in addition to your annual Preventive Exam that are covered at 100% by the EnerSys Medical Plan.

Your Preventive Schedule of benefits provides a listing of these services. You can find a copy of this listing on the member website at myhighmark.com. Once logged in, click on the “Wellness” tab to download your Preventive Schedule. Take a copy with you to your exam to show your Primary Care Physician what preventive services are eligible under your plan. You can also find your Preventive Schedule in the Medical folder in the Reference Center of benefitsolver.com.

For more information or education about Preventive Care, or to find a Primary Care Physician in your area, please contact Highmark Blue Shield at 833-227-9379 or visit myhighmark.com.

Who is Eligible?

EnerSys employees and spouses/domestic partners who are enrolled in the PPO or HDP Medical Plan and who complete their annual Preventive Exam are eligible for the Preventive Incentive credit.

What is the Incentive Credit?

The incentive credit is $300 for employees and $300 for spouses/domestic partners. If both the employee and their spouse/domestic partner receive their annual Preventive Exam, the total incentive credit will be $600. The Premium Incentive Credit is provided by way of a reduced medical insurance premium and is spread evenly across all paychecks in a calendar year.

When Should I get my Preventive Exam?

Complete your preventive exam during the 12-month period leading up to October 31 of the current year to receive the incentive credit the following calendar year.

What if I am a New Hire or New to the Medical Plan?

Employees hired prior to June 1st who choose to participate in the Medical Plan, as well as current employees who elect medical coverage for the first time by way of a Qualified Life Event prior to June 1st, will automatically be provided the incentive credit for the current year. These plan participants should complete their annual preventive exam by October 31st to earn the incentive credit for the following year.

Employees hired on or after June 1st who choose to participate in the Medical Plan, as well as current employees who elect medical coverage for the first time by way of Qualified Life Event on or after June 1st, will automatically be provided the incentive credit for the current year and following year. These plan participants should complete their annual preventive exam by October 31st of their first full year with medical coverage to earn the incentive credit for the following year.

How Can I Track my Progress?

To track your process and ensure your incentive credit has been properly applied, please log into your myhighmark.com profile.



MEDICAL PLAN FEATURES OFFERED AT NO COST

Top Provider Reimbursement Program

Your health is our priority. This is why EnerSys has partnered with Garner to support you alongside the EnerSys medical plan. Through Garner, qualified medical expenses are eligible for reimbursement of up to $1,000 for individuals and $2,000 for families.

Doctors, and not the facilities in which they work, have the proven greatest impact on the quality of your care. Garner's innovative solution analyzes the country's largest database of medical claim records to evaluate doctors based on real patient outcomes to find the Top Performing Providers. These Top Providers are usually nearby, in-network, and have appointment availability to see you.

Below are just a few examples of where Garner can be leveraged to find quality medical providers while making yourself eligible for reimbursement:

- Primary Care
- Pediatricians
- Dermatologists
- Mental Health Providers
  - Therapists
  - Psychologists
  - Psychiatrists
- Oncology
- Cardiology

Getting Started with Garner

When you visit a Top Provider, Garner will reimburse you for qualifying out-of-pocket medical costs. Please note, you must be enrolled in the EnerSys PPO or HDP medical plan to take advantage of the Garner program. To get started with Garner:

- Step 1 – When ready, sign up for your account at www.getgarner.com or by downloading the Garner app in your respective app store. When prompted, type in 'EnerSys' and then select the Group Name/Number that corresponds to the Group Name/Number on your Medical ID card.
- Step 2 - Search for your provider or the care needed and add them to your Garner Care Team. Providers MUST be added to your Care Team prior to your appointment to be eligible for reimbursement.
- Step 3 - Visit your providers for care. Once the claim has been processed by your insurance, it will be communicated to Garner for processing. Then, Garner will reimburse eligible expenses.
- Recommended:
  - Set up Direct Deposit once your benefit is active, as the default reimbursement method is by paper check. Direct deposit allows you to get your reimbursements up to two weeks sooner than by check.



Take some time to learn more about the Garner solution by visiting www.garnerguide.com/enersys

Garner and FSAs/HSAs

There are two primary IRS requirements for using your Garner reimbursement with tax-advantaged accounts like Healthcare FSAs and HSAs:

1. If you have already used your HSA or FSA funds to pay for a medical expense, you cannot request reimbursement for the same expense from Garner. The IRS prohibits “double dipping.”
2. If you are enrolled in the High-Deductible Plan (HDP), you must satisfy the annual medical deductible before getting reimbursed by Garner.

Garner Support

As your first line of expert assistance, the Garner Concierge Team can assist in understanding your benefit, finding Top Providers for yourself and your family, and/or answering questions about claims and benefits.

You can contact the Garner Concierge Team through:

- In-App messaging
- Phone at (866) 761-9586
- Email at concierge@getgarner.com

The Garner Concierge Team is available Monday – Friday from 8:00am - 8:00pm E.T.

Member Advocates and Personal Care Management

Highmark BlueShield member advocates can help you do more than learn about your benefits or review your medical claims. Highmark’s dedicated member services team is prepared to assist you with finding in-network providers, scheduling doctor appointments, resolving provider billing issues, transferring medical records, filing appeals, and more. Contact your advocate team by calling 833-227-9379, which is a one-stop shop for all member needs. You also have access to a specialized group of nurses, social workers, coaches and more. This team can:

- Give advice if you’ve been diagnosed with a serious condition, such as cancer, heart disease, or diabetes.
- Provide support before, during, and after a hospital stay.
- Coordinate and help you prepare for upcoming health care appointments.
- Offer access to virtual care management tools.
- Supporting your care journey, every step of the way.

In some cases, your nurse may reach out to you, so make sure your contact information in MyHighmark is up to date.

Highmark Community Support

The Highmark Community Support service can connect you or a covered dependent with various local social support services in your community. Members can search for local food pantries, housing and financial assistance, transportation, personal safety, and more. To access these resources, visit **www.highmark.findhelp.com**

Wellness Coaching

Access your Wellness Coaching Team who can offer services ranging from a single consultation to ongoing structured support through a comprehensive program addressing specific risk factors, including tobacco cessation, weight management, sleep, stress, general wellness and more at no cost to you.

You can enroll in a comprehensive telephonic program, including:

- How to Be Tobacco Free
- My Weight Management Journey
- Time to Sleep Well
- Aim for Change
- Stress Management

You can connect with a wellness coach by calling the phone number on the back of your ID card or dialing **800-650-8442**.

Teladoc Health Condition Management

Teladoc's Health Condition Management program consists of three condition-specific programs that offer a better, more effective way to manage diabetes, high blood pressure and weight at no additional cost to you. Each of these programs include access to myStrength, which provides evidence-based, personalized mental health support.

Diabetes Management

The Diabetes Management program supports people diagnosed with type 1 or type 2 diabetes and helps make living with diabetes easier. The program team works with you to provide personalized plans so you can live your healthiest life possible. The program gives you a connected meter and unlimited strips and lancets provided at no cost to you. You also have the option to work with a certified health coach for more guidance. If you prefer to receive support in Spanish, this option is available to you.

Hypertension Management

Get support for your high blood pressure with smart devices, expert coaches and easy-to-follow personalized plans. The program provides you with a connected blood pressure monitor and gives you access to personalized information to help you manage your condition better. You also have the option to work with a coach for more guidance. If you prefer to receive support in Spanish, this option is available to you.

Diabetes Preventive and Weight Management

Get support to help improve your weight loss, nutrition, exercise, sleep and stress at no cost to you. The program helps you lose weight and provides you with a connected scale to automatically track your progress. It connects you with a certified health coach who helps make living healthy and tackling your weight challenges easier. They can provide guidance on healthy habits so you can make healthy choices that line up with your tastes, lifestyle and goals. You will get personalized tips and techniques for you to improve your nutrition, exercise, weight loss, sleep and stress.

To Get Started

To get started with Teladoc's Health Condition Management program, visit teladochealth.com/go/ENERSYS or reach out by phone by calling 800-Teladoc. If prompted, the registration code, is ENERSYS.



24/7 Nurseline

Participants can get answers to health and medical questions with 24/7 access to the Blues on Call Nurseline. The Nurseline can help you manage your conditions with one-on-one nurse support for chronic diseases such as asthma, diabetes and heart disease. You can stay organized and on-top of your treatment plan with help from a nurse case manager if you have a critical health condition. To get started with a nurse, please call 888-258-3428 or log into MyHighmark, go to Get Care, and click on 24/7 Nurseline.

Baby Blueprints and Maternity Support

To help expectant mothers better understand every stage of pregnancy and make more informed care and lifestyle-related decisions, Highmark offers the Baby Blueprints Maternity Education and Support Program. This free program provides members with access to in-depth educational information on all aspects of pregnancy through multiple online offerings. Baby Blueprints also gives participants access to individualized support throughout their pregnancy from a nurse Health Coach. To enroll, expectant mothers can call 866-918-5267. Participants will then receive a confirmation mailing with helpful pregnancy tips. In addition to Baby Blueprints, Highmark's advocate team can assist expectant parents with reimbursement for Lamaze/Childbirth Education classes or help find a breast-pump supplier.

Blue365 Discounts

Take advantage of discounts on health and wellness products offered through this unique employee discount program. You are able to browse and redeem discount offers directly on the Blue365 website for things like hearing aids, weight loss coaching programs, workout apparel, pedometers, and fitness club memberships at some of your favorite Blue365 vendors nationwide. Visit www.blue365deals.com to enroll.



Virtual Physical Care – Powered by Sword Health

Virtual Physical Care allows participants to connect virtually with a licensed physical therapist to get real-time feedback and guidance.

What you get:

- Convenient, virtual access to physical therapists using a tablet, digital tools, and a phone-based app for easy communication.
- Guided exercises using sensor-based technology that's more accurate at detecting movement than the human eye.
- Zero out-of-pocket costs.
- A self-service option available on the Sword portal for members with lower-level joint and muscle issues.
- Information about cognitive behavioral therapy, as well as assistance and solutions for joint and muscle pain.
- Comprehensive support, including virtual visits, chat functions, guided feedback, and educational content.
- The flexibility and convenience to complete your guided exercise session from anywhere.

Virtual Pelvic Health Care: Bloom – by Sword Health

If you have pelvic pain, a bowel or bladder disorder, or issues related to pain during intimacy, pregnancy or postpartum, or menopause, this program can offer relief. This program is for women ages 18 and older.

- You meet virtually with a Pelvic Health Specialist.
- They'll design a program just for you.
- You'll receive a Bloom kit, which includes a device designed for internal use, called a Bloom pod. This device syncs with a program app that you can download to your mobile device.

WWW

GET IT ON Google Play

Download on the App Store

Recover stronger with Sword Health – virtual physical therapy and pelvic health support at no cost when you enroll in EnerSys medical coverage



TELEMEDICINE

With Highmark Well360 Virtual Health you can see a doctor anytime, anywhere from your smartphone, tablet or computer. Doctors can diagnose common illnesses and send prescriptions straight to your pharmacy. Plan participants can also utilize telemedicine to talk to a behavioral health specialist. Highmark Well360 Virtual Health is a feature of both the PPO Plan and HDP Plan. To keep all your health in one place, Well360 Virtual Health is now exclusively available in the MyHighmark app under the Get Care section. Participants can also contact Well360 Virtual Health by phone at 866-883-7358*.

SERVICES	EXAMPLES OF TREATMENT OR SUPPORT
Urgent Care	Allergies, Bronchitis, Strep Throat, UTI, Sinus Infection, Hypertension, Pink Eye, Gout, Cold Sores, Rashes, Stomach Flu and Acne
Therapy	Anxiety, Social Anxiety, Depression, Stress Management, Bereavement/Grief, OCD, PTSD/Trauma, Couples Therapy, Panic Attacks, Insomnia and Life Transitions
Psychiatry	Anorexia, Anxiety Disorders, Bipolar Disorder, Bulimia, Cognitive Disorders and Depression
Nutrition Counseling	Weight Loss, Digestive Disorders, Food Allergies, Gluten Free Diets, Pregnancy Diets, High Cholesterol, Sports Nutrition, Vegetarian Diets, Vitamins/Supplements and Meal Planning
Women's Health	Birth Control, Menopause, PMS, Postpartum Depression, UTI, Incontinence and Rashes

*Well360 Virtual Health phone support does not support behavioral health services.

GET IT ON Google Play

Download on the App Store



PRESCRIPTION DRUG



Prescription drug coverage is included with your EnerSys medical plan and administered by Navitus Health Solutions. With Navitus, you'll have access to 24/7 customer care, personalized support and convenient online and mobile tools to help you manage your prescriptions.

Your cost depends on the medication tier and the medical plan you choose. PPO participants do not need to meet a prescription deductible. HDP participants pay the full cost of prescriptions until the medical plan deductible is met, then pay the applicable copay until the annual out-of-pocket maximum is reached.

With Navitus, you get:

- 24/7 Customer Care
- Clinical Support
- Transition Support
- Online & Mobile Support

DRUG CATEGORY	YOUR PRESCRIPTION COST	
	RETAIL	90-DAY SUPPLY
Generic (Tier 1)	30 day: $10	$20
Preferred Brand (Tier 2)	30 day: 20% ($25 min/$50 max)	$75
Non-Preferred Brand (Tier 3)	30 day: 40% ($40 min/$80 max)	$120
Specialty (Tier 4)	1-30 day: 5% ($150 min/$250 max)	N/A

Prescription Drug Categories

1) Generic medications contain the same active ingredients as their brand-name equivalents and are generally the lowest-cost option.

2) Preferred brand medications are included on the plan's preferred drug list and generally cost less than non-preferred brand medications.

3) Non-preferred brand medications generally have higher out-of-pocket costs. Ask your provider whether a preferred or generic alternative may be available.

4) Specialty medications are used to treat complex or chronic conditions and may require special handling, administration or monitoring. A list of Specialty Drugs is available on the ***Lumicera Specialty Pharmacy*** website at www.lumicera.com/my-portal or you may call Lumicera at 855-847-3553.

Short-Term Prescriptions

For medications you need right away, such as antibiotics, use a participating network pharmacy. Present your Navitus member card when filling your prescription to receive the network benefit.

Broad Pharmacy Network

With Navitus, you have access to more than **63,000** participating retail pharmacies nationwide, including major national and regional chains. Eligible 30-day and 90-day prescriptions can be filled at participating network pharmacies, giving you greater flexibility and convenience.

Visit www.navitus.com to explore pharmacy network options and additional resources.

Maintenance Medications

If you take medication regularly for an ongoing condition, you may be able to fill a 90-day supply though:

- A participating pharmacy in the Navitus Maintenance Medication Network; or
- Costco Mail Order Pharmacy (no Costco membership required)

Maintenance medications generally include prescriptions used on an ongoing basis for conditions such as high blood pressure, diabetes, asthma or arthritis.

Your prescription plan may require a certain number of initial fills at a retail pharmacy before 90-day supplies are available.

Need help with a medication?

Navitus can help with prescription coverage questions, prior authorizations, medication transitions and lower-cost alternatives. Clinical support is also available for more complex medication needs.

Customer Care is available 24/7 at 844-268-9789

Your Navitus Resources

Google Play App Store



HEALTH SAVINGS AND FLEXIBLE SPENDING ACCOUNTS

EnerSys offers employees the ability to contribute pre-tax dollars into several different kinds of accounts. These funds can be used to pay for many eligible expenses you may be responsible for throughout the year. All Health Savings and Spending Accounts are administered through Empower.

Because of the beneficial tax treatment of these accounts, the IRS provides very specific guidelines about how funds can be contributed to these accounts, how they accumulate and how they can be spent. If you are considering contributing to a Health Savings or Spending Account, please review the information on pages 19 – 21 carefully and, if necessary, consult with your tax adviser.

MEDICAL, DENTAL AND/OR VISION EXPENSES

Health Savings Account (HSA)

The HSA allows you to contribute pre-tax dollars via payroll deduction into your own individually owned HSA bank account. These funds can then be used to pay for medical, dental and vision expenses helping you budget and save for qualified expenses.

Key HSA Facts

- HSA elections must be made every year if you wish to participate.
- HSA elections and contribution amounts can be changed at any point during the year.
- HSA funds can only be used after contributions are made. For a list of eligible expenses, please visit **www.empowermyretirement.com**.
- You may not contribute to an HSA if you contribute to an HCFSA.
- You can only contribute to an HSA if you are enrolled in the HDP Medical Plan.
- All funds roll over from year to year and there is no deadline to spend what you have contributed.
- Should your employment terminate for any reason, HSA funds are yours to take with you. Once your HSA contribution is made, that money is yours until spent on a qualified expense.
- HSA funds can also be spent on non-qualified expenses if 65 years of age or older (subject to regular income tax).
- Accounts must be established through Benefitsolver. Some may be subject to identity verification in accordance with the US Patriot Act of 2001. If this applies to you, you will be notified by Empower of next steps.



The EnerSys HSA Contribution

Employees who elect the HDP Medical Plan will be eligible to receive an EnerSys HSA matching contribution.

- Employee Only - $300 annually
- Employee + One or More - $600 annually

To receive the HSA employer contribution, you must establish an HSA through Benefitsolver and contribute via payroll deduction. Employee HSA contributions will be matched on a quarterly basis until the annual maximum employer matching contribution is reached.

Healthcare Flexible Spending Account (HCFSA)

The HCFSA allows you to contribute pre-tax dollars via payroll deduction into a specific account to be used to pay for medical, dental and vision expenses letting you budget and save for qualified expenses.

Key HCFSA Facts

- HCFSA elections must be made when initially eligible and or during Open Enrollment every year if you wish to participate. Once elected, the HCFSA cannot be changed during the year without a Qualifying Life Event.
- HCFSA funds can only be used to pay for eligible medical, dental and vision expenses incurred during the calendar year for which your election is made. For a list of eligible expenses, please visit www.empowermyretirement.com
- You may not contribute to a HCFSA if you contribute to an HSA.
- You can contribute to an HCFSA regardless of medical enrollment; however, they are typically paired with the PPO plan.
- It is not advisable to contribute to an HCFSA if you are enrolled in the HDP Plan. Instead, consider enrolling in an HSA.
- HCFSAs are frontloaded, meaning you will have access to your full elected annual contribution on the first day of the new plan year. Or if new to the plan mid-year, you will have access to your full elected annual contribution the date you enter into the plan.
- You may roll over $660 from one year to the next if you do not incur enough claims to deplete your HCFSA balance before the end of the year (this amount is subject to increase as the IRS releases new guidance).



CHILDREN AND/OR ELDERCARE EXPENSES

Dependent Care Flexible Spending Accounts (DCFSA)

The DCFSA allows you to contribute pre-tax dollars via payroll deduction into a specific account to be used for childcare and/or eldercare expenses letting you budget and save for qualified expenses.

Key DCFSA Facts

- DCFSA elections must be made when initially eligible and/or during Open Enrollment every year if you wish to participate. Once elected, the DCFSA cannot be changed during the year without a Qualifying Life Event.
- DCFSA funds can only be used to pay for eligible childcare and/or eldercare expenses incurred during the calendar year for which your election is made. Examples of eligible expenses include preschool, after-school care, daycare and non-overnight summer camps. For a full list of eligible expenses, please visit www.empowermyretirement.com.
- You can contribute to a DCFSA regardless of medical enrollment. You do not need to be enrolled in any medical plan to enroll in the DCFSA.
- DCFSAs are not frontloaded. This means funds can only be spent after they are accumulated in the DCFSA via payroll deduction.
- If you are married, both you and your spouse must work and earn income to qualify for reimbursement (unless one spouse is in between jobs and actively looking or is disabled and unable to work).
- If you are divorced, only the custodial parent may use a DCFSA.
- There is no rollover provision. Any funds remaining in your DCFSA at the end of the year will be forfeited.

ACCESSING AND SETTING UP YOUR SPENDING ACCOUNTS

Manage all your accounts in one place with a seamless connection to your workplace retirement plan online.

Follow these easy steps to get started:

- At the beginning of your benefit plan year, log in to www.empowermyretirement.com or the Empower mobile app with the username and password you use for your workplace retirement account. You'll find your Consumer Directed Health Account(s) in the Account dropdown. Select the account name and click Overview. Select Visit website, and a new page will load.
- If you've never registered your workplace retirement account online or don't have one, from the login page:
  - Choose Register.
  - Select I do not have a PIN.
  - Enter your personal information and create a username and password.

Be sure to view the educational articles, interactive videos and calculators contained on this page. Administratively, you can do all of the following and more:

- View all your account balances
- Submit claims and upload receipts
- View all transactions, claims, and status and receive email or SMS notification of claim payments
- Report a card as lost or stolen, which cancels the card and ships you a new one
- Change default reimbursement method and direct deposit info
- Make online payment(s) to any payee
- Add/change beneficiaries



Download the Empower Benefit Accounts Mobile App

Manage your account on the go with an app just for your Consumer-Directed Health account benefits. If you're using the Empower Benefit Accounts app for the first time, click SignUp to register and follow the prompts. Be sure you respond to the text message that will be sent to you to complete your registration.

Please note: The Empower Benefit Accounts app is separate from the Empower app used for your retirement account and only includes information related to your FSA or HSA. The registration process for the Empower Benefit Accounts app is separate from and not connected to your retirement account.

Remember:
All current benefit elections will carry over from one plan year to the next EXCEPT Health Savings Account (HSA) and Flexible Spending Account (FSA) elections. If you would like to contribute to either the HCFSA or DCFSA in the new plan year, you must make that election during Open Enrollment (or when initially eligible as a new hire or PT-FT transfer). If you do not elect to make an FSA contribution during this time, you may only change your election during the plan year if you experience a Qualified Life Event.

HSA elections can be changed at any point during the plan year, but must be elected during Open Enrollment if you would like your HSA deduction for the new plan year to start with your first paycheck of the new plan year.



VOLUNTARY BENEFITS

To allow maximum customization of your employee benefits, EnerSys has contracted with Voya to provide and administer three Voluntary Benefits. These benefits can be elected with or without medical enrollment, and provide cash distributions for various conditions, incidences or circumstances. These cash distributions can always be used however you see fit and are never required to be used to offset medical expenses.

Below is a summary of each of the three Voluntary Benefits available. For additional information, definitions of available benefits, and exclusions/limitations, please review the plan summaries, brochures and/or Certificates of Coverage found in the Document Center of Benefit Solver.

Critical Illness Insurance

Wellness Benefit Eligible

Critical Illness Insurance offers financial protection for you and your family during the difficult time following the diagnosis of a serious illness or condition. No medical questions or tests are required for coverage.

There are two coverage options available to you and your family: the Low Plan ($10,000 coverage amount) and the High Plan ($20,000 coverage amount). You are able to cover yourself and any member of your family deemed to be an eligible dependent. If you or a covered dependent are ever diagnosed with a listed condition, the benefit will trigger, and you will receive the full value of the coverage amount (unless explicitly stated in the Certificate of Coverage to be an amount less than 100% of the policy value). Benefits can be paid out multiple times. Below is a list of covered conditions. Remember, to receive the benefit, you only need to be diagnosed with the condition.



Wherever noted “Wellness Benefit Eligible”, be sure to read the Wellness Benefit Section on page 26 and understand how you can earn up to $100 per year for yourself and each covered dependent by completing an eligible health screening test.

*The full $100 would require enrollment in both Accident Insurance and Critical Illness Insurance and the completion of an eligible health screening test.

* A sudden cardiac arrest is not in itself considered a heart attack.
** Major organ transplant means the irreversible failure of your heart, lung, pancreas, entire kidney or liver, or any combination thereof, determined by a physician specialized in care of the involved organ.
*** Diagnosis of a severe infectious disease by a doctor, including COVID-19, when a diagnosis occurs on or after the coverage effective date; AND confinement to a hospital for 5 or more days, or in a transitional facility for 14 or more consecutive days.

COVERED CONDITION	BENEFIT
Heart attack*	100%
Cancer	100%
Stroke	100%
Major organ transplant**	100%
Coronary artery bypass	25%
Carcinoma in situ	25%
Transient ischemic attacks (TIA)	10%
Ruptured or dissecting aneurysm	10%
Abdominal aortic aneurysm	10%
Thoracic aortic aneurysm	10%
Open heart surgery for valve replacement/repair	25%
Severe burns	100%
Transcatheter heart valve replacement/repair	10%
Coronary angioplasty	10%
Implantable ICD placement	25%
Pacemaker placement	10%
Benign brain tumor	100%
Skin cancer	10%
Bone marrow transplant	25%
Stem cell transplant	25%
Permanent paralysis	100%
Loss of sight, hearing or speech	100%
Coma	100%
Amyotrophic lateral sclerosis (ALS)	100%
Parkinson’s disease	100%
Advanced dementia, including Alzheimer’s disease	100%
Huntington’s disease	100%
Infectious disease (hospitalization requirement) ***	25%
Addison’s disease	10%
Myasthenia gravis	50%
Systemic lupus erythematosus (SLE)	50%
Systemic sclerosis (scleroderma)	10%



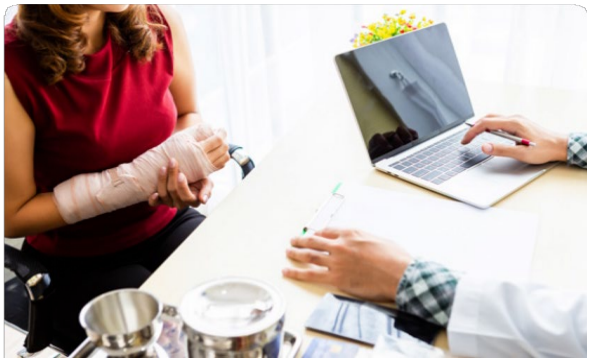
ACCIDENT INSURANCE

Wellness Benefit Eligible

Accident Insurance pays benefits for specific injuries and events resulting from an accident. The benefit amounts depend on the type of injury and treatment received. No medical questions or tests are required for coverage.

There are two coverage options available to you and your family: the **Low Plan** and the **High Plan.** You are able to cover yourself and any member of your family deemed to be an eligible dependent. If you or a covered dependent suffer an injury due to an accident that requires treatment, if that injury, treatment or service is listed in the Schedule of Benefits, a cash distribution will be made. The Schedule of Benefits contains over 100 covered injuries and treatments/services. Below is a condensed schedule of eligible injuries/services/treatments:

Cash distributions can always be used however you see fit and are never required to be used to offset medical expenses.



INJURY/EVENT	LOW PLAN	HIGH PLAN
Hospital admission	$1,000	$2,000
Hospital confinement*	$225	$275
Critical care unit confinement**	$450	$550
Rehabilitation confinement***	$125	$200
Lodging****	$120	$180
Initial doctor visit	$60	$90
Follow-up doctor treatment	$60	$100
Urgent Care treatment	$150	$225
Emergency room treatment	$225	$275
Ground Ambulance	$240	$360
Air ambulance	$1,000	$1,500
Medical equipment	$75	$200
Physical Therapy*****	$30	$45
Speech Therapy*****	$30	$45
Prosthetic device (one)	$500	$750
Prosthetic device (two or more)	$800	$1,200
Major diagnostic exam	$125	$275
X-ray	$50	$75
Emergency dental work (crown)	$250	$350
Blood, plasma, platelets	$400	$600
Ruptured disk (surgical repair)	$500	$800
Concussion	$150	$225
Paralysis (paraplegia)	$10,750	$16,000
Paralysis (quadriplegia)	$16,000	$24,000
Lacerations (varies by severity)	$20-$320	$30-$480
Burns (varies by severity)	$1,000-$10,000	$1,250-$15,000
Various joint dislocations (non-surgical)	$175-$2,550	$275-$3,850
Various joint dislocations (surgical)	$350-$5,100	$550-$7,700
Various bone fractures (non-surgical)	$160-$2,240	$240-$3,360
Various bone fractures (surgical)	$320-$4,480	$480-$6,720
Tendon/ligament/rotator cuff (varies by severity)	$275-$800	$425-$1,225

* per day, up to 365 days
** per day, up to 15 days
*** per day, up to 90 days
**** per days, up to 30 days
***** up to 6 per accident

Sports Accident Benefit Rider

EnerSys has chosen to include the Sports Accident Benefit Rider. If your accident, or the accident of a covered dependent, occurs while participating in an organized sporting activity (as defined in the Certificate of Coverage) all benefits, with the exception of fractures or dislocations, will be increased by 25% to a maximum of $1,000.

Exclusions and Limitations

Standard exclusions for the Certificate, Spouse Accident Insurance, and Children's Accident Insurance are listed in the plan's Certificate of Coverage the plan's Benefit Summary.

HOSPITAL INDEMNITY INSURANCE



Hospital Indemnity Insurance provides financial protection in the form of a fixed daily benefit should you or a covered family member require a stay in the hospital*. Benefit amounts are determined based
on the type of facility and the duration of the hospital stay. No medical questions or tests are required for coverage.

There are two coverage options available to you and your family: the **Low Plan** and the **High Plan**. You are able to cover yourself and any member of your family deemed to be an eligible dependent. If you or a covered dependent have a covered stay in a hospital, intensive care unit**, or rehabilitation facility, you will receive a cash distribution for each day of confinement. Any combination of facility confinement and admission benefits payable include a limit. Below is a basic flow of how this benefit works.

When your stay begins:

When admitted to a covered medical facility, a plan participant becomes eligible for an admission benefit for the first day of confinement. This benefit is paid once per confinement, up to a maximum of 8 admissions per calendar year.

Type of Admission	Low Plan	High Plan
Hospital Admission	$1,000	$2,000

As your stay continues:

Beginning on Day 2 of a plan participant's confinement, for each day confined in a covered facility, that plan participant will be eligible for a fixed daily benefit payment. The benefit amount and maximum number of days per confinement varies by facility.

TYPE OF FACILITY	DAILY BENEFIT (LOW PLAN)	DAILY BENEFIT (HIGH PLAN)
Hospital (31 day max per confinement)	$100	$200
Intensive Care Unit (31 day max per confinement)	$100	$200
Rehabilitation Facility (31 day max per confinement)	$50	$100
Observation Unit***	$100	$100

If you add a child to your family:

Hospital Indemnity Insurance benefits apply if you have employee or spouse/domestic partner coverage and are hospitalized for childbirth. In addition, your newborn child may be covered as well.

- If child coverage is effective before the child is born, benefits will apply just as they would for any other child.
- If child coverage is not effective before the child is born, be sure to add your newborn child as a Qualifying Event to coverage within 30 days to take advantage of an additional benefit amount.

* A hospital does not include an institution or part of an institution used as: a hospice unit, including any bed designated as a hospice or swing bed; a convalescent home; a rest or nursing facility; a free-standing surgical center; an extended care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care, or care for the aged.

** An Intensive Care Unit may be referred to as a "Critical Care Unit" in your certificate of coverage. An ICU Transitional Care Unit may be referred to as a "CCU Step-Down Unit" in your policy documentation. Refer to your policy documentation for complete definitions and descriptions of each facility type.

*** At least 4 consecutive hours, other than inpatient. Maximum 1 day per calendar year. Not payable for any day that a facility confinement or admission benefit is payable.

WELLNESS BENEFIT

The Wellness Benefit is included with both Accident Insurance and Critical Illness Insurance coverage. The Wellness Benefit provides an annual benefit payment of

$50 if you complete a covered health screening test on or after your coverage effective date, whether or not there is any out-of-pocket cost to you. The Wellness Benefit can be claimed once per year, even if you complete multiple tests. Any covered spouse/domestic partner and/or children are also eligible for the Wellness Benefit if they complete a health screening test on or after their coverage effective date.

Below is a list of some of the eligible health screening tests. If you want to know if a specific screening test is covered that isn't on this list, please review the Certificate of Coverage or contact Voya at 877 236-7564.

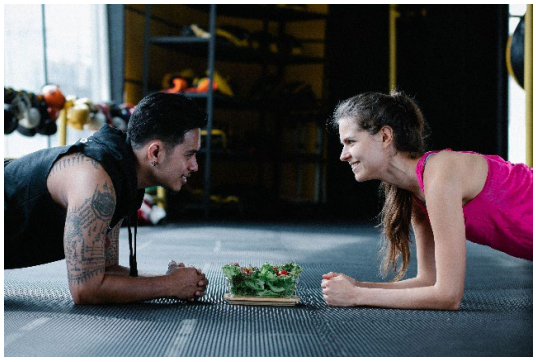


Blood test for triglycerides	Mammography	Routine eye exam
Flexible sigmoidoscopy	Colonoscopy	Routine dental exam
CEA (blood test for colon cancer)	CA 15-3 (breast cancer)	Well child/preventive exams (ages 1-18)
Bone marrow testing	Stress test of bicycle or treadmill	Biometric screening
Hemoccult stool analysis	Fasting blood glucose test	Electrocardiogram (EKG)
Breast ultrasound, sonogram, MRI	Thermography	Annual Physical Exam – Adults
Molecular or antigen COVID-19 test	PSA (prostate cancer)	Hemoglobin A1C
Chest x-ray	Hearing test	Bone density screening

Once your screening test is completed, visit the Voya Benefits Resource Center at: **https://presents.Voya.com/EBRC/EnerSys.**

- Group policy name: EnerSys, Inc.
- Group policy number: 731307

Complete the questions regarding the health screening test and electronically sign and submit your Wellness Benefit claim. A confirmation number will be provided for your reference, as well as the option to save the form for your records.



Remember:
Each covered plan participant can receive the Wellness Benefit once per year FOR EACH ENROLLMENT. That means, if you and your family are enrolled in both Critical Illness Insurance and Accident Insurance, each covered plan participant can receive the Wellness Benefit twice per year!

DENTAL INSURANCE

Employees who enroll in the Delta Dental PPO Plan will be able to visit any licensed dentist; however the benefit value will be maximized by taking advantage of Delta's nationwide PPO network.

PPO vs. Premier Dentists

A Delta Dental Premier Dentist is a Participating Dentist but is not a Delta Dental PPO Dentist. Premier Dentists have agreed to accept payment less discounted than a PPO Dentist. To maximize your savings, always try to visit a PPO Dentist.

Locating a Delta Dental Dentist

To find a dentist, search the Delta Dental web site at www.deltadentalins.com. The Delta portal allows plan participants to search by distance, specialty, language spoken, extended office hours, wheelchair accessibility and more. Participants can also review DentaQual scores for an objective quality metric based on actual claims data. Participants can also call Delta Dental at 800-932-0783 for representative assistance.

Pre-Treatment Estimates

If you and your dentist are unsure of your benefits for a specific course of treatment, or if treatment costs are expected to exceed $300, Delta Dental recommends that you ask for a pre-treatment estimate. You should ask your dentist to submit the claim form in advance of performing the proposed services. Pre-treatment estimate requests are not required but may be submitted for more complicated and expensive procedures such as crowns, wisdom tooth extractions, bridges, dentures or periodontal surgery. You will receive an estimate of your share of the cost and how much the plan will pay before treatment begins.

Specialists

Your dentist may refer you to a dental specialist for treatment. In this case, be sure that the specialist you are referred to participates in the Delta network. You can do this by simply asking the specialist when you make your appointment.

Remember, if the specialist does not participate in the Delta network, you may be required to pay all treatment costs at the time of service and submit a claim to Delta Dental for reimbursement at the out of network rate.



Delta Dental PPO Benefit Summary

SERVICES	BASIC	ELITE	ELITE PLUS
Annual Deductibles	$50 per person/$100 per family	$25 per person/$75 per family	$25 per person/$75 per family
Annual Maximums	$1,000 per person	$1,500 per person	$3,000 per person
Waiting Period	None	None	None
Benefits and Covered Services			
Diagnostic & Preventive Services	100%	100%	100%
Basic Services Filings	80%	80%	80%
Endodontics (root canals)	80%	80%	80%
Periodontics (gum treatment)	80%	80%	80%
Oral Surgery	80%	80%	80%
Major Services	50%	50%	50%
Prosthodontics	50%	50%	50%
Implants	0%	0%	50%
Orthodontic Benefits – Children Only	0%	50%	50%
Orthodontic Maximums	$0	$1,500 lifetime per child	$3,000 lifetime per child



VISION INSURANCE

Vision coverage is provided by VSP nationwide. Plan participants are able to visit any eye doctor, however savings will be maximized by visiting an in-network eye doctor. You can find a local list of in-network eye doctors by visiting www.vsp.com or by calling their customer service center at 800-877-7195. An ID card is not required for you to receive services. At your appointment, tell the provider you have VSP and work for EnerSys, or you can print a member vision card from the Member Details section of the VSP website.

VSP Vision Benefit Summary

IN NETWORK BENEFITS	DESCRIPTION	COPAY	FREQUENCY
WellVision Exam	Focuses on eyes and overall wellness	$10	Every calendar year
Prescription Glasses		$20	
Frame	$150 allowance for a wide selection of frames $170 allowance for featured frame brands 20% savings on the amount over your allowance $80 Costco® frame allowance	Included in Prescription Glasses	Every other calendar year
Lenses	Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every calendar year
Lens Enhancements	Standard progressive lenses Premium progressive lenses Custom progressive lenses Average savings of 20-25% on other lens enhancements	$0 $95-$105 $150-$175	Every calendar year
Contacts (instead of glasses)	$150 allowance; contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
OTHER SERVICES			
Lightcare	Use your frame & lens benefit to get nonprescription eyewear from a VSP in-network provider. Members can use their frame allowance towards either non-prescription blue light filtering glasses, or sunglasses.		In place of frame & lens allowance
Diabetic Eyecare Plus Program	Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply.	$20	As needed
Additional Savings	Glasses and Sunglasses Extra $20 to spend on featured frame brands. Go to vsp.com/special offers for details. 20% 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 $39 copay on routine retinal screening as an enhancement to a WellVision Exam. Laser Vision Correction Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.		

Vision Plus

With the Vision Plus option, participants will be able to receive their frame allowance once every year (with a $20 copay) as opposed to once every other calendar year. In addition, those who elect the Plus option can customize care with EasyOptions. Participants can personalize coverage by choosing one of the following enhancements:

- an additional $50 contact lens allowance or
- an additional $100 frame allowance or
- fully covered progressive lenses or
- fully covered photochromic lenses or
- fully covered anti-reflective lenses

Be sure to ask your provider how best to leverage EasyOptions during your exam.

Laser VisionCare

The VSP Laser VisionCare Program provides members with discounts through VSP-contracted laser facilities. Discounts average 15-20% off or 5% off a promotional offer for laser vision surgery including PRK, LASIK, and Custom LASIK2. With Laser VisionCare through VSP, receive a complimentary screening to determine if you are a candidate for vision surgery, pre-operative eye exam to measure the degree of vision correction needed, and post-operative exams to ensure your eyes heal properly during recovery.

LIFE INSURANCE

Company Paid Life Insurance

Life Insurance

This plan provides a post-tax benefit equal to one and a half times your annual base salary*, up to $1,000,000, to your designated beneficiaries. This benefit is provided at no cost to you.

Accidental Death and Dismemberment Insurance

This plan also provides a post-tax benefit equal to one and a half times your base annual salary if your death results from an accident. Additional benefits are available for dismemberment and vary based on the loss. This benefit is also provided at no cost to you.

Guaranteed Issue

Employees who elect up to $500,000 of Employee Paid Life Insurance, and/or up to $20,000 Spouse Life Insurance when initially eligible will be provided with the elected coverage amount without the need to provide Evidence of Insurability. However, if Employee Paid Life Insurance or Spouse Life Insurance is not elected when initially eligible, or you are currently enrolled in Employee Paid Life or Spouse Life Insurance and request an increase of more than one salary tier during open enrollment, employees may be required to provide Evidence of Insurability. Prudential, in their sole discretion, would decide to either approve or deny the request for additional or increased life insurance coverage.



*Annual base salary excludes overtime, bonuses, shift premiums and other incomes that may increase your paycheck (commissions are included for Sales Representatives based on a one-year average). Benefits are determined based on your annual base salary at the time of claim.

Employee Paid Life Insurance Options

Life Insurance

This voluntary plan provides a post-tax benefit equal to between one to five times your annual base salary, up to $1,000,000 depending on your election. This is in addition to any benefit paid by the company-provided coverages discussed on this page.

Accidental Death and Dismemberment Insurance

Employee Only - This voluntary plan provides a post-tax benefit equal to one to five times your annual base salary if your death results from an accident. Additional benefits are available for dismemberment and vary based on the loss.

Employee + Family - This voluntary plan provides a post-tax benefit equal to one to five times your annual base salary if your death results from an accident. Spousal/Domestic Partner coverage is equal to 50% of the principal sum, and child coverage is equal to 10% of the principal sum. Additional benefits are available for dismemberment and vary based on the loss.

Spouse/Domestic Partner Life Insurance

You may elect to cover your spouse/domestic partner up to $100,000 of life insurance in $10,000 increments.

Child Life Insurance

You may elect to cover your dependent children with up to $10,000 of life insurance, in $2,000 increments.

Automatic Reduction

Company Paid Life Insurance/AD&D and Employee Paid Life/ AD&D Insurance are subject to automatic reduction based on age. Coverage amounts will be reduced to 65% of the original value at age 65 and 50% of the original value at age 70.

ADDITIONAL BENEFITS BUNDLED WITH YOUR BASIC LIFE INSURANCE BENEFIT



Will Preparation

Employees have access to Prudential's Estate Guidance Program, an online resource for the preparation of a will, living will or power of attorney. Services for Will Preparation and Final Arrangements are available at no cost to you. Note that Living Wills/ Power of Attorney are available at a discounted fee. Services offered include:

- Will Preparation - define your most important decisions, such as who will care for your children or inherit your property.
- Final Arrangements – provides interactive questionnaire to assist with preparing which arrangements you wish to make, what information you will need to compile and how to communicate your wishes to your loved ones before or after your death.
- Living Will Preparation - ensures your final wishes are carried out and protects loved ones from having to make difficult and personal medical decisions regarding the use of extraordinary life-support if you should become incapacitated and unable to communicate your wishes. *
- Designate Power(s) of Attorney – allows you to plan ahead by designating someone known and trusted to act on your behalf in the event of unexpected occurrences or if you become incapacitated.*

* Note that Living Wills/Power of Attorney are available at an additional cost.

Personalized Care Plan with Empathy - As a Prudential group life policyholder, Empathy gives Prudential beneficiaries complimentary on-demand help with the steps and emotional challenges following a loss. Empathy offers a personalized care plan with a step-by-step plan tailored to your needs with everything you need to make progress. Empathy provides an understanding of the probate process and guidance on whether it can be avoided. Lastly, Empathy offers Grief Support where beneficiaries can find supportive resources to help them cope with difficult days and challenging emotions. Visit www.prudential.com/caringforyou for personalized care services.

Grief Counseling - To help beneficiaries cope with loss, Prudential offers personalized grief counseling sessions. Any beneficiary who receives a life insurance proceed is eligible for up to three face-to-face counseling sessions along with an unlimited 24/7 toll-free line staffed by clinical professionals. These sessions can be in-person or by phone with a network of counselors who provide professional, confidential support during difficult times.

Well-being Hub - A digital hub where you can build your financial confidence and get help with planning for life's events. You'll enjoy easy access when you log onto www.prudential.com/wellbeing-hub for resources such as:

- Credit and debit management
- Credit report review
- Housing counseling
- Student loan counseling
- Caregiving support
- Insurance needs calculators
- Library of articles

Travel Assistance Services - Prudential partners with IMG that has extensive experience handling complex and remote medical transport situations, as well as providing support for travel concerns when they arise. The team of international, multilingual specialists are accustomed to working across time zones and with different languages and currencies. Utilizing IMG's extensive global network of medical care providers, their onsite 24/7/365 U.S. based call center is available day or night to provide high-quality care you can depend on. Toll-free within the U.S.: 1-855-847-2194. From anywhere in the world: 1-317-927-6881.

DISABILITY INSURANCE

Short Term Disability

Short Term Disability Insurance pays a percentage of your salary (or hourly wage) if you become temporarily disabled due to your own sickness or injury (excluding on-the-job injuries, which are covered by Worker's Compensation Insurance).

Short Term Disability benefits may run concurrently with FMLA. Employees may be required to use their available vacation time or Paid Time Off to satisfy the Qualifying Period prior to receiving benefits. In order to receive STD benefits, the injury or illness must be on or after the effective date of coverage, all eligibility requirements must be met and claims must be initiated and approved by Telus Health.

Please refer to the Company FMLA and STD policies for further details.

Paid Parental Leave

Employees designated as full-time who have been employed by the company for at least 31 days are eligible for four (4) weeks of Paid Parental Leave at 100% of hourly or salary wages. In order to receive Paid Parental Leave benefits, the child must be born or adopted on or after the effective date of coverage, all eligibility requirements must be met and claims must be initiated and approved by Telus Health.

Coordination of Benefits with State Paid Family Leave (PFL) Programs

You may also be entitled to State Paid Leave Benefits that run concurrently with STD depending on your state of employment. Telus Health and Prudential will partner to process and pay PFL claims. For statutory PFL inquiries, please contact Prudential at 800-842-1718.

Leave of Absence (LOA)/Short Term Disability Reporting

It is essential to report absences related to an LOA or STD in a timely manner. To report, please call Telus Health at 1-833-844-5807 and provide the following information:

- Employee ID, last name and date of birth

Telus Health will create your claim and provide you with a confirmation number by the end of the call. Please keep this confirmation number for future use.

Schedule of Benefits

Benefits are paid for each regularly scheduled workday that the employee is Totally Disabled. Benefits are payable after the Qualifying Period has been satisfied, and all other plan provisions are satisfactorily met. Payments coincide with your usual pay cycle; semi-monthly or bi-weekly. Benefits are paid for a maximum of 26 weeks (including the Qualifying Period).

Long Term Disability

Long Term Disability Insurance can offer peace of mind and financial security if you find yourself unable to return to work for a period of at least 180 days due to a covered injury or illness. Coverage is based on your annual base salary with a maximum monthly distribution of $15,000: 60% income replacement.

If this coverage is elected when you first become eligible to participate, it is guaranteed to be issued without medical inquiry; however, the pre-existing conditions limitation will apply. If elected outside of initial eligibility, Evidence of Insurability may be required.

If elected, deductions for Long Term Disability Insurance are taken from your paycheck on a post-tax basis, which means any future distributions will also be post-tax.

For Long Term Disability inquiries, please contact Prudential at 800-842-1718.

If you are enrolled in Long Term Disability and are eligible to file a claim, information will be mailed to your home address that will detail your rights and responsibilities under the plan.

For a comprehensive list of exclusions, limitations, applicable benefit offsets, and duration of benefits for disability plans, please refer to the Certificate of Insurance found on the Benefit Solver website. The Certificate also provides all requirements necessary to be eligible for coverage and benefits.



IDENTITY THEFT PROTECTION



Control & Manage

Credit Report Lock

Lock or unlock access to your Multi-Bureau credit reports (Equifax and TransUnion®) through your ID Watchdog account with certain exceptions.

Child Credit Lock

Activate a Child Credit Lock for your minor child to help better protect against credit fraud in their name by creating an Equifax credit report for your child, then locking it to prevent access to it by potential lenders and creditors.

Financial Accounts Monitoring

Set custom alert triggers for credit card, checking, savings, and investment accounts so you can monitor account balances and transactions and watch for signs of fraudulent activity.

Social Account Takeover Alerts

Notifies you within minutes if we detect social media account activity that could indicate account takeover of a monitored social media account.

WWW

GET IT ON Google Play

Download on the App Store

ID Watchdog, an Equifax product, is an industry leader in identity theft protection, detection, and restoration services. In addition to coverage for yourself, you are able to add coverage for all dependents for a small premium. Below are just some of the features this service offers. This benefit can be elected at any point during the plan year (not just during Open Enrollment).

Personal VPN & Safe Browsing

Access the internet securely and privately with a NordVPN account. Get high-speed, encrypted connections on up to 6 devices at the same time.

Password Manager

Create and store complex passwords and synchronize and manage passwords across devices.

Integrated Fraud Alerts

Through your dashboard, activate fraud alerts on your credit reports across the three nationwide credit bureaus and provide your contact information. Fraud alerts encourage lenders to take extra steps to verify your identity before extending credit.



Monitor & Detect

Credit Report Monitoring

Monitors your credit report from all three nationwide credit bureaus (Equifax, TransUnion, Experian®) and provides alerts of activity, which if unexpected, could be a sign of potential fraud.

Child Credit Monitoring

Scans the Equifax credit database for a child's Social Security number and alerts you if a credit file potentially exists or is created under your child's identity.

Identity Profile Report

Provides up to a 30-year look back of verified and unverified records associated with your identity to establish your baseline identity profile for future monitoring.

Dark Web Monitoring

Scans websites, chat rooms, and other forums known for trafficking stolen personal and financial information for compromised credentials, including Social Security numbers.

Data Breach Notifications

Alerts you if your personal information has been associated with a reported data breach or was detected through our dark web scans.

High-Risk Transactions Monitoring

Alerts you if we detect in the monitored network, a high-risk validation performed by a financial institution using your identity.

Public Records Monitoring

Scours billions of public records and other databases, including licenses and certifications, to search for new names or addresses associated with your identity which, if unexpected, could be a sign of a potential identity theft.

Credit Report(s) & VantageScore Credit Score(s)

Update your 1-Bureau credit report and VantageScore® 3.0 credit score based on Equifax data daily. This also includes annual 3-Bureau credit reports and 3-Bureau VantageScore credit scores.

Up to $1 Million is identity theft insurance included.

Support & Restore

Fully Managed Resolution including Pre-Existing Conditions

Assigns one of our highly trained and certified resolution specialists to your identity theft case—your case is fully managed until it is resolved. Includes full-service resolution for pre-existing identity theft regardless of when it occurred.

Online Resolution Tracker

View the status of your open identity theft case and keep track of the communication with your assigned certified resolution specialist through your online dashboard.

Identity Theft Insurance

Up to $1 Million identity theft insurance that provides reimbursement for certain out-of-pocket costs related to the recovery of your identity. Includes stolen funds reimbursement for unrecoverable, fraudulent electronic transfers from checking, savings, and money market accounts.

Lost Wallet Vault & Assistance

Assists you with cancelling and replacing the wallet contents added to Dark Web Monitoring (e.g., credit and debit cards and government-issued identification) in the event of a lost or stolen wallet.



EMPLOYEE ASSISTANCE PROGRAM

No matter what issues you or a family member are facing, your EAP, offered through Spring Health, is a turnkey first step to finding needed mental health support. Whether you're looking to reduce stress and anxiety, improve sleep, strengthen relationships, or cope with life's challenges, Spring Health can help.

And it's available at no additional cost to all EnerSys employees and their immediate family members. Remember, we take our responsibility to protect your privacy seriously, and all services are confidential in accordance with federal and state laws.

Access the below great features through your Spring Health EAP:

- Fast Access to Provider Visits – Employees and their family members can typically see a high-quality provider within three days or less. Employees and their family members can take advantage of up to six (6) employer-sponsored therapy sessions each year. Two of those sessions may be used for medication management if needed. If you are on the EnerSys medical plan with Highmark Blue Shield, once you've used your employer-sponsored sessions, you can continue to see the same Spring Health provider as all Spring Health providers are considered in-network. If you are not on the EnerSys medical plan with Highmark Blue Shield, once you've used your employer-sponsored sessions, you can continue to see the same Spring Health provider. Spring can assist with submitting a claim to your health insurance or help you find an in-network provider.
- Personalized Care Plans – A quick digital assessment that screens for numerous mental health conditions. Once the assessment is completed, participants will receive a customized care plan matched to the identified needs.
- Licensed Care Navigators – Care Navigators provide clinical guidance and personalized referral support to EnerSys employees and their family members. They can explain assessment results/care plans for you or your family members, help identify mental health resources, and provide additional emotional support when you need it. All Care Navigators are licensed mental health clinicians. Appointments are unlimited and do not count toward your sponsored sessions.
- Certified Coaches – Coaches can help you build better habits, navigate life transitions, improve communication skills, and set/achieve your goals. Spring Health offers coaches who specialize in personal development, professional development, health and wellness, and parenting categories. Spring Health also now offers Teen Coaching. Coaching is unlimited for employees and family members.
- Digital Exercises – A library of on-demand exercises is available that can help you get immediate relief from pressing concerns and build long-term skills that can support mental wellness, stress and anxiety management, symptoms of burnout, sleep improvement and mindfulness.
- Work-Life Services – Expert guidance and resources to navigate legal or financial matters, child care, elder care, travel, household services, and more.

Highmark Associate Membership

Whether you're enrolled in EnerSys medical coverage or not, all employees are now Associate Members with Highmark through the EAP. With Associate Membership, you and your family have access to:

- Your Employee Assistance Program (available at no cost to employees and their family members age 6+)
- Discounts on gym memberships, personalized weight loss, coaching, acupuncture, yoga, massage and more through Blue 365. More information on Blue 365 can be found in the Medical section of this guide. You can also click on the benefits tab of **www.MyHighmark.com**, select Member discounts, and create your free Blue 365 Discounts account with your member ID.

To register, visit **www.MyHighmark.com**. Here, employees can activate their account, schedule appointments, and get support at their convenience. Employees can also invite an eligible household member to use the EAP by sending them an invite with a unique link to access the program.

- For individual support, call Spring Health at 1-844-931-4465. They're available for:
- Benefit questions or scheduling support, Monday–Friday, 8a.m. – 11p.m.
- Individual crisis support from a licensed clinician, 24/7.

Below are just a few examples where Spring Health can help:

- Relationship issues
- Anxiety
- Depression, sadness, or irritability
- Excessive fears, worries, or anxieties
- Social withdrawal
- Inability to cope with daily problems or activities
- Suicidal thoughts
- Denial of obvious problems
- Substance use
- Prolonged negative mood
- Difficulty focusing at work
- Grief and loss
- Adoption issues
- Domestic abuse
- Financial issues
- Childcare
- Eldercare
- Legal assistance
- College planning
- Parenting problems



EMPLOYEE DISCOUNTS

EnerSys has partnered with PerkSpot to bring you and your family access to a private marketplace of discounts providing savings from many of the nation's top brands. Save on items and services in over 25 categories including apparel, automotive, gifts, food, health & fitness, pets, tickets/attractions, travel and more. Check out your employee discount provider at enersys.perkspot.com. New discounts are being added frequently, so check back often!



401(K) RETIREMENT PLAN

Automatic Enrollment

Newly hired employees are automatically enrolled in the plan on the first of the month following 60 days of employment, at a pre-tax contribution rate of 6% of eligible compensation. You may choose to opt-out of automatic enrollment or elect a contribution percentage other than the automatic 6% if you prefer. Employees who opt-out of automatic enrollment and rehired eligible employees will need to make an active election by visiting www.empowermyretirement.com.



Your Contributions

You can contribute up to 75% of your eligible compensation to the plan on a pre-tax, after-tax, and/or Roth basis, up to the IRS limit.

- If you are age 50 or older, you may be able to make "catch-up" contributions to your account, up to the IRS limit. If you are age 60-63, you may be able to make additional catch-up contributions as permitted by IRS rules.
- Pre-tax contributions are payroll deducted before you pay current income taxes. Earnings on your pre-tax contributions, along with your pre-tax contributions, are taxed only when you take a distribution from the plan.
- Regular after-tax contributions are payroll deducted after you pay income tax. The earnings on your regular after-tax contributions are taxed when you receive a distribution.
- Roth contributions are a type of after-tax contribution and are payroll deducted after you pay current income taxes. Unlike regular after-tax contributions, you can receive the earnings from your Roth contributions tax-free if you have a qualified distribution.

Employer Contributions

EnerSys is proud to invest in your retirement by matching your deferral contributions. Matching contributions and earnings are taxed when you take a distribution from the plan. A matching contribution equal to the specified rate for the corresponding level of each of your elective deferral percentages is listed in the chart to the below:

EMPLOYEE CONTRIBUTION	ENERSYS MATCH CONTRIBUTION	TOTAL CONTRIBUTION
1%	2%	3%
2%	3%	5%
3%	4%	7%
4%	5%	9%
5%	5.5%	10.5%
6%	6%	12%

Vesting

You are 100% vested in your own contributions and EnerSys' matching contributions. This means the value of your contributions, company matching contributions, and any earnings are yours when you leave the company.

Investment Choices

The plan allows you to choose from a wide range of funds to build a diversified account. For more information about the funds in the plan, log on to www.empowermyretirement.com. Simply click your plan name and select Investment Lineup under Investments.

If you have questions about your account, call Empower Retirement at 844-465-4455. Representatives are available weekdays from 8:00am - 10:00pm and Saturdays from 9:00am - 5:30pm Eastern Standard Time. You can access your account online at **www.empowermyretirement.com**.

Newly hired eligible employees are automatically enrolled in the plan on the first of the month following 60 days of employment



ANNUAL DISCLOSURE NOTICES

This document includes the following important Annual Enrollment legal notices for EnerSys.

- HIPAA Privacy Practices
- HIPAA Special Enrollment Rights
- Women's Health and Cancer Rights Act of 1998
- Newborns' & Mothers' Health Protection Act
- COBRA Rights
- Medicaid and the Children's Health Insurance Program (CHIP)

Notice of Privacy Practices for EnerSys Health and Welfare Plan

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

This Notice is directed to and applies to the associates of EnerSys (the "Company") who participate in or are eligible to participate in the Company's Health and Welfare Plans (the "Plans"). This Notice applies to medical/prescription drug, dental and health flexible spending accounts offered under the Plans. Please note that this Notice does not entitle you to benefits for which you are not eligible, or for which you do not enroll.

Protected health information that is created, received or maintained by the Plans when they provide medical, dental, health flexible spending account and employee assistance benefits is protected by federal privacy law. Protected health information is information that identifies you and relates to your physical or mental condition, to the provision of health services to you, or to the payment for your health services. Protected health information is referred to as "health information" in this Notice.

This Notice informs you how the Plans use and disclose your health information and explains the rights that you have with regard to your health information created, received or maintained by the Plans. This Notice is required by federal health privacy laws. This Notice will remain in effect unless and until the Plans publish a revised Notice.

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 the Company as an employer — that's the way the HIPAA rules work. Different policies may apply to other Company programs or to data unrelated to the Plan.

Information Subject to This Notice

The Plans create, collect and maintain health information to help provide health benefits to you and your eligible dependents, as well as to fulfill legal requirements. The Plans collect this health information, which may identify you or your eligible dependent, from applications and other forms that you complete, through conversations you may have with the Plans' administrative staff and health care providers, and from reports and data provided to the Plans by health care providers, insurance companies or other third parties. The health information the Plans have about you includes, among other things, your name, address, phone number, birth date, Social Security number, employment information, and claims information. This is the information that is subject to the privacy practices described in this Notice.

Information Not Subject to This Notice

The Company helps the Plans perform many essential tasks, such as collecting enrollment information, deciding eligibility and transmitting payment for premiums and claims. The information collected by the Company when it is performing these tasks is not health information and is not subject to the privacy practices described in this Notice.

In addition, the Plans provide other benefits that are not related to health benefits, such as short-term disability benefits, long-term disability benefits and life insurance benefits. The Plans' administrative staff and the Company request, receive, store and disclose your medical information so they can administer these non-health benefits. The Plans' administrative staff and the Company receive this medical information either voluntarily from you or from your health care provider. You may need to provide your written consent to your health care provider if you want your health care provider to communicate directly with the Plans' administrative staff or the Company. After medical information is disclosed by you or your health care provider for these purposes, it is not considered health information, and it is not subject to the privacy practices described in this Notice.

In addition, you should know that the Company cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by the Company 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)."

The Plans' Uses and Disclosures of Your Health Information

Generally, the Plans use and disclose your health information without your consent for the administration of the Plans and for processing claims. 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. In unusual cases, the Plans may disclose your health information without your consent for other purposes as permitted by the federal privacy law, such as health and safety, law enforcement or emergency purposes. If the Plan uses or discloses health information for underwriting purposes, the Plan will not use or disclose health information that includes your genetic information for such purposes. Generally, you must give your written consent for all other uses and disclosures of health information covered by these privacy practices.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

1. **For Treatment.** The Plans may use and disclose your health information to a health care provider, such as a hospital or physician, to assist the provider in treating you. For example, if a Plan maintains information about interactions between your prescription medications, the Plan may disclose this information to your health care provider for your treatment purposes.

2. **For Payment.** The Plans may use and disclose your health information so that your claims for health care services can be paid according to their terms. For example, if a Plan has a question about payment for health care services that you received, the Plan may contact your health care provider for additional information.

3. **For Health Care Operations.** The Plans may use or disclose your health information so it can operate efficiently and in the best interests of its participants. For example, a Plan may disclose health information to its auditors to conduct an audit involving the accuracy of claim payments.

Uses and Disclosures to Business Associates

The Plans may disclose your health information to third parties that assist the Plans in their operations. For example, the Plans may share your health information with their business associates if the business associates are responsible for paying medical claims for the Plans. The Plans' business associates have the same obligation to keep your health information confidential as the Plans do. The Plans require their business associates to ensure that your health information is protected from unauthorized use or disclosure.

Uses and Disclosures to the Plan Sponsor

The Plans may disclose your health information, without your consent, to the Company for administrative purposes, such as determining the amount of benefits you or your eligible dependent are entitled to from the Plans, determining or investigating facts that are relevant to a benefit claim, determining whether your benefits should be terminated or suspended, performing duties that relate to the establishment, maintenance and or administration of the Plans, communicating with you about the status of claims, recovering any overpayment or mistaken payments made to you, and handling issues related to subrogation and third party claims. Benefits, payroll, and /or finance staff are the only EnerSys employees who will have access to health information for plan administration functions.

Other Uses and Disclosures That May Be Made Without Your Written Consent

The federal health privacy law provides for other uses or disclosures of your health information without your written consent, such as the following activities:

1. **Required by Law.** The Plans may use and disclose your health information as required by federal, state or local law. For example, the Plans may disclose your health information for judicial and administrative proceedings pursuant to legal process and authority, to report information related to victims of abuse, neglect, or domestic violence, or to assist law enforcement officials in their law enforcement duties.

2. **Health and Safety.** Your health information may be disclosed to avert a threat to the health or safety of you, any other person, or the public, pursuant to applicable law. Your health information also may be disclosed for public health activities, such as preventing or controlling disease or disability and meeting the reporting and tracking requirements of governmental agencies such as the Food and Drug Administration.

3. **Government Functions.** Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities and protection of public officials. Your health information also may be disclosed to health oversight agencies that monitor the health care system for audits, investigation, licensure, and other oversight activities.

4. **Active Members of the Military and Veterans.** Your health information may be used or disclosed to comply with laws related to military service or veterans' affairs.

5. **Workers' Compensation.** Your health information may be used or disclosed in order to comply with laws related to Workers' Compensation.

6. **Emergency Situations.** Your health information may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency, or to a disaster relief entity in the event of a disaster.

7. Others Involved In Your Care. Your health information may be used or disclosed to a family member, a close personal friend, or others whom the Plans have verified are involved in your care or payment for your care. For example, if you are an eligible dependent, the Plans may send your Explanation of Benefit forms to the participant, or answer the participant's questions about the payment of a claim that involves your care. If you do not want this information to be shared, you may request that these disclosures be restricted as outlined later in this Notice.

8. Personal Representatives. Your health information may be disclosed to people you have authorized or people who have the right to act on your behalf. Examples of personal representatives are parents for unemancipated minors and those who hold powers of attorney for adults.

9. Treatment and Health-Related Benefits Information. The Plans and their business associates may contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you, including, for example, alternative treatment, services or medication.

10. Research. Under certain circumstances, the Plans may use or disclose your health information for research purposes, as long as the procedures required by law to protect the privacy of the research data are followed.

11. Organ and Tissue Donation. If you are an organ donor, your health information may be used or disclosed to an organ donor or procurement organization to facilitate an organ or tissue donation or transplantation.

12. Deceased Individuals. The health information of a deceased individual may be disclosed to coroners, medical examiners,
and funeral directors so that those professionals can perform their duties.

13. 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.

Uses and Disclosures for Fundraising and Marketing Purposes

The Plans do not use your health information for fundraising or marketing purposes.

Any Other Uses and Disclosures

Except as described in this notice, any uses and disclosures of your health information other than those described above will be made only with your express 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. Once your health information has been disclosed pursuant to your written consent, the federal privacy protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your knowledge or consent. You may revoke your written consent in writing. If you do so, the Plans will not use or disclose the health information described in the written consent unless the Plans have already acted in reliance on that written consent. You will be notified of any unauthorized access, use or disclosure of your unsecured health information as required by law.

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 Rights

You have the following rights regarding the health information that the Plans create, collect and maintain. If you are required to submit a written request to enforce any of these rights, you should address such request to the HIPAA Contact Person.

Right to Inspect and Copy Health Information

Generally, you have the right to inspect and obtain a copy of the health information that is maintained by the Plans and their business associates. This includes, among other things, health information about your eligibility, coverage, claim records and billing records. To inspect and copy your health information, you must submit your request in writing. The Plans may charge you a copying fee that includes a copying fee per page and the cost of mailing the health information to you. In certain limited circumstances, the Plans may deny your request to inspect and copy your health records and they will inform you of such a denial in writing. In certain instances, if you are denied access to your health information, you may request a review of the denial.

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 of 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 Request Confidential Communication, or Communications by Alternative Means or at an Alternative Location

You have the right to request that the Plans and their business associates communicate your health information to you in confidence by alternative means or in an alternative location. For example, you can ask that the Plans and their business associates contact you only at work or by mail, or that the Plans and their business associates provide you with access to your health information at a specific, reasonable location.

To request confidential communications by alternative means or at an alternative location, you must submit your request in writing.

Your written request should state the reason(s) for your request and the alternative means by or location at which you would like to receive your health information. The Plans will make their best effort to accommodate reasonable requests and will respond to your request appropriately.

Right to Request That Your Health Information Be Amended

You have the right to request that the Plans amend your health information if you believe the information is incorrect or incomplete. To request an amendment, you must submit a detailed written request including the reason(s) that support your request. The Plans may deny your request if it is not in writing, it does not provide a reason in support of the request, or if you have asked to amend information that was not created by the Plans (unless the person or entity that created the information is no longer available to make the amendment), is not part of the heath information maintained by or for the Plans, is not part of the health information you would be permitted to inspect and copy or it is accurate and complete. The Plans will notify you in writing whether they accept or deny your request for the amendment. If the Plans deny your request, they will explain the reason(s) for the denial, and describe how you can continue to pursue the requested amendment.

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 an Accounting of Disclosures

You have the right to receive a written accounting of the disclosures of your health information by the Plans and their business associates. The accounting is a list of disclosures of your health information by the Plans and their business associates to others. 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. Generally, the following disclosures are not part of an accounting: disclosures that occur before the effective date of this Notice or are not otherwise covered by this Notice, disclosures for treatment, payment or health care operations, disclosures made to you, or disclosures for which you gave the Plans written consent, disclosure to family members or friends involved in your care (where disclosure is permitted without authorization), disclosure for national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances or disclosure s as part of a "limited data set" (health information that excludes certain identifying information) An accounting includes the disclosures that have occurred during the six-year period before your request (but not before the effective date of this Notice). To request an accounting of disclosures, you must submit your request in writing. If you want an accounting that covers a period of less than six years, please state that in your request. The first accounting that you request during a twelve-month period is provided at no charge. For any additional accountings in the same twelve-month period, the Plans will charge you for the cost of providing the accounting. In this case, the Plans will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred.

Right to Request Restrictions

You have the right to request restrictions on the health information that the Plans use or disclose about you to carry out treatment, payment or health care operations. Also, you have the right to request restrictions on your health information that the Plans disclose to someone who is involved in your care or the payment for your care, such as a family member or a friend. The Plans are not required to agree to your request for such restrictions, and the Plans may terminate their agreement to the restrictions you request. To request restrictions, you must submit your request in writing, and advise the Plans what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. The Plans will notify you in writing whether they agree to your request.

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 for the item or service, in full out-of-pocket.

Right to Complain

You have the right to complain to the Plans if you believe the Plans or their business associates have not complied with the federal privacy laws in any way. To file a complaint with the Plans, you must submit your complaint in writing to the HIPAA Contact Person listed below. Alternatively, you may file a complaint with the Department of Health and Human Services. You will not face retaliation or be discriminated against and no services, payment, or privileges will be withheld from you because you file a complaint with the Plans or with the Department of Health and Human Services.

Right to a Paper Copy of This Notice

You have the right to obtain a paper copy of this Notice upon request. You must submit a written request to the HIPAA Contact Person.

Changes in the Plan's Privacy Practices

The Plans must abide by the terms of the privacy notice currently in effect. This notice takes effect on 1/1/2019. The Plans reserve the right to change their privacy practices, by action of the Privacy Officer, and to make the new practices effective for all health information that they create, collect and maintain, including your health information that they created, collected or received before the effective date of the change. If the Plans materially change any of these privacy practices, they will notify you of the change no later than 60 days after the change is made by email (if provided a company email) or notified via mail. Additional copies of the notification will be made available to you upon your written request.

HIPAA Contact Person

HR Shared Services:
Phone: 833-305-4090
Email address: **hrss@enersys.com**

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) in EnerSys health because of other health insurance or group health plan coverage, later you may be able to enroll yourself and your dependents in some coverages under this Plan without waiting for the next open enrollment period, if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage). Additionally, you and/or your dependent(s) may be able to enroll in a Company sponsored medical plan if you and/or your eligible dependent(s) either:

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

You must request enrollment within 60 days — instead of 31 — of an event that involves loss of Medicaid or CHIP coverage or eligibility for a state's premium assistance program under Medicaid or CHIP. Note that this 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

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. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. If you request a change due to a special enrollment event within the applicable timeframe, coverage will be effective on the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment.

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

Women's Health and Cancer Rights Act of 1998

The Act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications, including lymphedema, at all stages of the mastectomy

This coverage will be provided in consultation with the attending physician and the patient and will be subject to the same annual deductibles and coinsurance provisions that apply for other medical and surgical benefits covered under the medical plans. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the plan descriptions. If you would like more information on WHCRA benefits, call your plan administrator at 1-800-338-7807 (Aetna), 1-800-826-9781 (UMR), 1-800 or 1-800-464-4000 (Kaiser).

Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers generally may not 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

Uniformed Services Employment and Reemployment Rights Act (USERRA)

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- you ensure that your employer receives advance written or verbal notice of your service;
- you have five years or less of cumulative service in the uniformed services while with that particular employer;
- you return to work or apply for reemployment in a timely manner after conclusion of service; and
- you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right To Be Free From Discrimination and Retaliation If you:

- are a past or present member of the uniformed service;
- have applied for membership in the uniformed service; or
- are obligated to serve in the uniformed service;
- then an employer may not deny you because of this status:
  - initial employment;
  - reemployment;
  - retention in employment;
  - promotion; or
  - any benefit of employment

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement

- The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at **http://www.dol.gov/vets.** An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm.**
- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: **http://www.dol.gov/vets/programs/userra/poster.htm**. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

General Notice of COBRA Continuation Coverage Rights Introduction

You are receiving this notice because you are participating or have recently become eligible for benefits under the EnerSys Health and Welfare Plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan, as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

You may have other options available to you when you lose group health coverage.

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact your Company representative.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for this coverage.

If you are an associate, you will become a qualified beneficiary if you lose your coverage under the Plan because either of the following qualifying events happen:

1. Your hours of employment are reduced.
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an associate, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happen:

1. Your spouse dies.
2. Your spouse's hours of employment are reduced.
3. Your spouse's employment ends for any reason other than his or her gross misconduct.
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both) and is not an active associate.
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happen:

1. The parent associate dies.
2. The parent associate's hours of employment are reduced.
3. The parent associate's employment ends for any reason other than his or her gross misconduct.
4. The parent associate becomes divorced or legally separated.
5. The parent-associate becomes enrolled in Medicare (Part A, Part B or both) and is not an active associate.
6. The child stops being eligible for coverage as a "dependent child" under the Plan.

When Is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Company has been notified that a qualifying event has occurred.

When the qualifying event is the end of employment or reduction in hours of employment, death of the associate, commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the associate in Medicare (Part A, Part B or both) if the associate is not an active associate, the Company will automatically notify the COBRA Administrator.

You Must Give Notice of Some Qualifying Events

For other qualifying events (divorce or legal separation of the associate and spouse or a dependent child losing eligibility for coverage as a dependent child), you must notify the Company within 60 days after the qualifying event occurs. This notice must be provided in writing to your Company contact and must include the name of the associate, name of the qualified beneficiary(ies) who will receive COBRA coverage and the type and date of event that gave rise to COBRA coverage.
Depending upon the qualifying event, your Company contact may request supporting documentation.

How Is COBRA Continuation Coverage Provided?

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered associates may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the associate, enrollment of the associate in Medicare (Part A, Part B, or both) if the associate is not an active associate, your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage can last for up to 36 months. When the qualifying event is the end of employment or reduction of the associate's hours of employment, and the associate became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the associate can last until 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE termination or reduction of hours. For example, if a covered associate becomes entitled to Medicare eight months before the date on which his employment terminated, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

Otherwise, when the qualifying event is the end of employment or reduction of the associate's hours of employment, COBRA continuation coverage lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation coverage can be extended.

Disability Extension of 18 Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely manner, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some point before the 60th day of COBRA continuation coverage and must last at least until the end of the 18 month period of COBRA continuation coverage. You must make sure that the COBRA Administrator is notified of the Social Security Administration's determination within 60 days of the determination and before the end of the 18 month period of COBRA continuation coverage.

Second Qualifying Event Extension of 18 Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage for a maximum of 36 months. This extension may be available to the spouse and dependent children receiving COBRA continuation coverage if the associate or former associate dies, enrolls in Medicare (Part A, Part B or both), if the associate is not an active associate, or gets divorced or legally separated. The extension is also available to a dependent child when the child stops being eligible under the Plan as a dependent child. In each case, however, the extension of COBRA continuation coverage will apply only if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all these cases, you must make sure that the COBRA Administrator is notified of the second qualifying event within 60 days of the second qualifying event.

Special Rule for the Health Care FSA

Extension of coverage for the Health Care FSA is limited to the end of the year in which the qualifying event occurs. However, an individual who is covered under COBRA continuation coverage on December 31 of any Plan year can submit claims for expenses incurred during the Grace Period (the period from January 1 through March 15) following the Plan year.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.
You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit
https://www.medicare.gov/medicare-and-you.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to WageWorks at 1 (877) 722-2667.

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. 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: dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance
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/healthinsurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-partyliability/childrens-health-insurance-program-reauthorizationact-2009-chipra
Phone: 678-564-1162, Press 2

ILLINOIS – Medicaid
Illinois Medicaid Premium Assistance Information Medicaid application website: abe.illinois.gov
HIPP Hotline Number: 1-217-524-8268
HIPP Email: mhfs.boc.hipp@illinois.gov

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: hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 1-888-346-9562

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 1-877697-6703 (LaHIPP)

MAINE – Medicaid
Enrollment Website: mymaineconnection.gov/benefits
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: mydss.mo.gov/mhd/healthcare
Phone: 1-573-751-2005

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/programsservices/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: nj.gov/humanservices/dmahs/individuals-families/familycare
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
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: 1-866-614-6005

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: 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: scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Uta h's Premium Pa rtnership for Hea lth Insura nce (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: dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website:
https://coverva.dmas.virginia.gov/learn/premiumassistance/famis-select
https://coverva.dmas.virginia.gov/learn/premiumassistance/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: bms.wv.gov
Website: 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-andeligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
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 approximately seven minutes per respondent. 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, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.96% of your modified adjusted household income in 2026.

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