2023 Benefits Annual Enrollment

Frequently Asked Questions (FAQs)
U.S. Standard

If you have a specific question, see if it's in the list below and click on the link to be taken directly to the answer you're looking for. Otherwise, browse and scan the FAQs at your own pace.

If you have a question not answered here, call the DXC Benefits Center at 1.877.627.4015, 8 a.m. to 8 p.m. ET, Monday through Friday.

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Benefits Annual Enrollment

1. When is Benefits Annual Enrollment?

2023 Benefits Annual Enrollment—your opportunity to choose your benefits for next year—is Monday, November 14 through Tuesday, November 29, 2022.

2. What's changing for 2023?

The following changes are effective January 1, 2023:

- As is the case every year, pricing for the medical, dental and vision plan options through the Aon Health Exchange will change in 2023.
- Starting in 2023 you can now enroll your domestic partner in DXC benefits (medical, dental, vision and dependent life).
- You have an opportunity to insure your eligible pet through MetLife Pet Insurance, a new offering, which provides a 10% group discount plus additional multi-pet and military/first-responder/healthcare discounts.
- IRS limits are increasing for HSA contributions in 2023 to $3,850 for individual coverage and $7,750 for family coverage, so you can contribute more to your HSA if you are enrolled in a high deductible health plan (HDHP) medical option (Bronze, Bronze Plus, Silver). If you are age 55 or older (or will turn age 55 during 2023), you can also make additional "catch-up" contributions up to $1,000.
- The DXC 2023 Health FSA contribution limit is $3,050. You can roll over any unused Health FSA balance up to allowable amounts—$570 from 2022 to 2023 and $610 from 2023 to 2024.
- The DXC 2023 Dependent Care FSA contribution limit is continuing at $2,500 per parent if filing tax returns separately and $5,000 if filing jointly. Any unused 2022 funds in your Dependent Care FSA will be forfeited.
- The MetLife Legal Plan coverage is enhanced to include an additional four hours of attorney services for matters not typically covered, at no additional payroll deduction cost to you.
- The number of payroll deductions may be different in 2023, according to your legacy company designation, because of the DXC U.S. payroll initiative. The payroll deduction amounts in the interactive pricing tool (see **FAQs 37 and 38**) and enrollment portal have incorporated this change.

3. What can I do to prepare for Benefits Annual Enrollment?

Visit the **2023 Benefits page on myDXCbenefits.com** for helpful resources, including an enrollment checklist and **Reference Guide**. The new **myDXCbenefits.com** site replaces the Make It Yours website and brings DXC benefits and resources all together in one convenient online location so you will always know where to start your benefits exploration. No login is required, so it's easy for you (and your spouse/domestic partner) to access anytime.

4. What do I need to do during Benefits Annual Enrollment?

This is your once-a-year opportunity to review and make changes to your benefits for 2023. Your current choices may no longer be best for you and your family as plan pricing is changing. Explore your options available and consider your needs carefully, so you can make the best decisions for the year ahead.

Log in to the **DXC Benefits Center enrollment portal**, November 14-29, 2022, and take action to:

- Review your plan costs for 2023.
- Update your benefits elections, including switching to a lower cost carrier and/or another medical plan for your health care.
- Elect a 2023 Health Savings Account (HSA), if eligible, if you want to contribute money from your paycheck or have your 2023 wellness incentives deposited to this account.[1]
- Contribute to a tax-advantaged Flexible Spending Account (FSA) for health care and/or dependent day care expenses.

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- Add a dependent to your coverage, including a domestic partner, if applicable.
- Elect disability income protection (i.e., short-term and long-term disability).[2]
- Elect or increase your supplemental life (including dependent life)[2] and/or supplemental AD&D insurance.

To enroll, log in to the **DXC Benefits Center enrollment portal** and follow the prompts to choose your 2023 benefits. When you enroll, use the Help Me Choose decision support tool to compare and choose your health plan options based on your health care needs, cost preferences, how deductibles work, your prescription drugs and your preferred providers.

If you newly enroll in medical coverage, you also need to complete the tobacco attestation. If you newly enroll your spouse/domestic partner in medical coverage, you must complete the working spouse/domestic partner attestation.

[1]If you do not elect an HSA for 2023, your existing DXC HSA will move to a retail (i.e., non-DXC-sponsored) account, and a Health Reimbursement Account (HRA) will be opened for any 2023 wellness incentives earned.

[2]Don't wait to enroll in these coverages until you need them. Enrollment in these coverages is subject to evidence of insurability (EOI) rules, which means you must submit evidence of good health for the insurance carrier to review, and coverage is subject to denial.

5. What happens if I don't enroll?

If you don't actively enroll during Benefits Annual Enrollment for 2023, your current medical, dental, vision, life and Short-term and Long-term disability elections carry over at 2023 prices, you cannot contribute to an FSA and/or your HSA defaults to waive. If you do not elect an HSA for 2023, your existing DXC HSA moves to a retail (i.e., non-DXC-sponsored) account and, if you earn any 2023 wellness incentives, a Health Reimbursement Account (HRA) will be opened for you.

After November 29, you cannot elect or change your benefits until next fall's Benefits Annual Enrollment, unless you have a qualifying life event (such as marriage or birth).

6. Who do I contact if I have questions about my 2023 benefits or how to enroll?

If you have questions about your 2023 benefits or Benefits Annual Enrollment, call the DXC Benefits Center at **1.877.627.4015** from 8 a.m. to 8 p.m. ET, Monday through Friday. Alternatively, you can schedule an appointment to have someone from the DXC Benefits Center contact you—log in to the **DXC Benefits Center enrollment portal** and click on the *Schedule time with a Rep* tile.

If you need additional help choosing benefits to best meet your needs, contact Alight Advocacy Team at by phone at 800.513.1667 or email at **AlightHealthPro@alight.com**.

7. If my medical plan premiums are increasing, what can I do to mitigate the increase?

Explore your options and consider switching to another plan and/or carrier. The exchange offers you a degree of choice and control you would not have in a traditional benefit platform. You can:

- Select a lower-cost carrier for your current medical plan.
- Do the math to find out if a different medical plan might be better for you financially:
  - Consider a lower metallic coverage level—it's often a better financial decision.
  - The cost of your medical plan is more than the payroll deduction amount. Consider the deductible amount, the deductible type, the out-of-pocket maximum and the eligible tax-favored account (e.g., if you choose a high-deductible health plan (HDHP), you could make pre-tax contributions to a Health Savings Account (HSA)).
  - If you enroll in an HDHP—Bronze, Bronze Plus and Silver—you can earn wellness incentives in the form of company contributions to your company-sponsored HSA (see **FAQ 47**).
  - Before Benefits Annual Enrollment starts November 14, use the interactive pricing tool to understand your financial exposure (see **FAQs 37 and 38**).
  - Once Benefits Annual Enrollment starts November 14, use the Help Me Choose tool to compare your health plan options based on your health care needs, cost preferences, how deductibles

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work, your medications and your preferred providers—and choose the plan that is best for you and your family. You can access Help Me Choose when you enroll through the **DXC Benefits Center enrollment portal**.

8. Who's eligible for benefits?

Full-time employees—those who have a regular work schedule of 30 or more hours per week—are eligible for DXC benefits. See the detailed **eligibility requirements** to learn about eligibility for family members.

9. Is my common law spouse eligible for benefits?

Common law marriage is recognized in a handful of states. The requirements for common law marriage vary by state and are defined by local law; therefore, a valid common law marriage compliant with the statutory requirements where it was established is considered a legal marriage under the plan. Note that all dependents are subject to verification and the dependent verification process includes a process for verifying common law marriages.

10. Is my domestic partner eligible for benefits?

Yes. Domestic partners (and the dependent children of domestic partners) are eligible for DXC benefits, effective January 1, 2023. To include a domestic partner (and/or or dependent child(ren) of your domestic partner) in your coverage, you must add them during Benefits Annual Enrollment, November 14-29, 2022.

Under federal tax laws domestic partners are not considered tax dependents, so the value of your domestic partner's coverage is included in your taxable income. This is called "imputed income".

If you choose domestic partner coverage, your contributions will be deducted from your paycheck on a pre-tax basis (just like contributions for spouses and dependent children) but will be credited back to you as taxable imputed income in compliance with the federal tax requirements. The total taxable imputed income reflected in your paycheck will include your contribution and the value of DXC's contribution for your domestic partner's coverage.

To better understand the tax implications for you, consult with your tax advisor.

11. What benefits are available to me?

If you are regularly scheduled to work 30 or more hours per week, the following optional benefits are available to you. You must make an active enrollment to be covered by these benefits:

- Medical insurance
- Dental insurance
- Vision insurance
- Health Savings Account (HSA), if you enroll in a Bronze, Bronze Plus or Silver medical option
- Health Reimbursement Account (HRA), if not eligible for an HSA
- Health Flexible Spending Account (FSA), if you enroll in a Gold or Platinum medical option or waive medical coverage (if you enroll in a Bronze, Bronze Plus or Silver medical option, your Health FSA is a Limited Purpose Health FSA)
- Dependent Care FSA
- Commuter reimbursement account
- Supplemental and dependent life insurance
- Supplemental accidental death and dismemberment (AD&D) insurance
- Short-term disability insurance
- Long-term disability insurance
- Critical illness insurance
- Hospital indemnity insurance
- Accident insurance

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- Legal services
- Identity theft protection
- Auto and home insurance
- Pet insurance

You are automatically enrolled in the following benefits, which are 100% company paid:

- Basic life insurance
- Basic AD&D insurance
- Business travel AD&D insurance
- DXC LifeManagement Program (EAP)
- DXC Employee Discount Program (Perks at Work)
- Torchlight Caregiver and Parent Support Services

You can learn more about all these benefits at **myDXCbenefits.com**.

Dependent Verification

12. Do I have to provide documentation to verify my dependents?

Yes. It is DXC's policy to verify the eligibility of all dependents covered on DXC benefit plans. If you add a dependent who has not been verified recently, you will be asked to submit verification documents. Documentation may include marriage certificate, birth certificate, joint tax return or other documents as described in the verification request.

13. Why do I need to verify my dependents?

The DXC employee health and welfare plans provide for the coverage of certain dependents under company-sponsored medical, dental, vision, life management and dependent life insurance benefits. There are several reasons for requiring dependent verification: 1) the plan documents have specific eligibility provisions; 2) the cost of providing benefits to ineligible dependents is shared by the company and by other legitimate participants; 3) failure to follow the terms of the plan documents can also result in the loss of favorable tax status for benefits from all of these plans, which means that the benefits would be taxable to employees; and 4) verification is necessary to meet the reporting requirements under the Affordable Care Act.

To ensure the plans are being administered according to the terms of the plan documents and therefore retain the tax benefits for all participants, ongoing verification and periodic audits are necessary. We recognize that it's not always convenient for employees to produce the required documentation; however, dependent verification is considered a best practice in benefit plan management and is very common at large employers.

14. What happens if I don't submit the required documentation to verify my dependent?

If the DXC Benefits Center does not receive the requested verification documents from you by the deadline stated in your verification notice, your dependent(s) will be dropped from coverage as of the deadline date. If you want to have your dependent reinstated, you must submit a claim to the DXC Benefits Center along with all the required verification documents. If your claim is approved, your dependent will be reinstated prospectively as of the date all valid verification documents are received and not retroactive to the date coverage was dropped.

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Aon Active Health Exchange™

15. What is an exchange?

An exchange is a way for you to get medical, dental and vision coverage. It is an online insurance marketplace where buyers like you can shop for coverage from multiple health insurance carriers that are competing for your business. An exchange merges the best of both worlds—group rates with more individual choice and price competitiveness that comes from free-market competition.

The Aon Active Health Exchange is America's first national large employer multi-insurance carrier exchange. Its website is easy to navigate and, just like other online stores, you'll be able to see all your options and sort by the features that are most important to you. By the time you complete your enrollment, you should feel confident that you've selected the right insurance carriers and coverage options for your circumstances and budget.

16. Is Aon's exchange sponsored by the government?

No. The Aon Active Health Exchange is a private exchange. It is unrelated to the government-run state and federal health insurance exchanges or marketplaces. It does, however, provide benefits consistent with the law and guarantees coverage for those eligible, regardless of pre-existing conditions.

17. Does DXC sponsor my health coverage?

Yes. It is important to know that DXC continues to sponsor your benefits and share the cost of buying coverage with you. Your benefits are still DXC group health plans. Utilizing the exchange is simply a way for us to offer you choice and administer your benefits.

18. If I enroll in a Gold medical plan, do I have to enroll in a Gold dental and vision plan?

No. You elect (or waive) each benefit separately. For example, you could elect Gold medical, waive dental and elect Bronze vision.

19. What are the advantages of the exchange?

The medical and prescription drug, dental and vision benefits available through the exchange offer you:

- **Lots of choices.** You're able to choose from a variety of insurance carriers, several plan options (metallic levels—Bronze, Bronze Plus, Silver, Gold and Platinum) and a range of costs.
- **Competitive pricing.** The insurance carriers are competing for your business. So it is in their best interest to offer their best prices. Plus, DXC provides a credit for you to use toward the cost of medical and dental coverage.

In addition, you have the option to enroll in other valuable benefits—including critical illness insurance, hospital indemnity insurance, accident insurance, legal services and identity theft protection. Also, you can get discounted rates for auto, home and pet insurance through the exchange.

20. Are all DXC benefits part of the exchange?

No. DXC also offers important benefits such as life insurance, accidental death & dismemberment, short- and long-term disability. Although these plans are not part of the exchange, they are administered by the DXC Benefits Center.

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21. Where can I get more information?

Website resources	Before you enroll	When you enroll	After you enroll
myDXCbenefits.com	Explore DXC benefits on **myDXCbenefits.com**. This benefits site replaces the Make It Yours website and brings DXC benefits and resources all together in one convenient online location so you will always know where to start your benefits exploration. No login is required, so it's easy for you (and your spouse/domestic partner) to access anytime.		
Interactive pricing tool and Help Me Choose	Use the interactive pricing tool before you enroll to compare the cost of your health care options based on your situation (see **FAQs 37 and 38**).	When you enroll, use the Help Me Choose tool (a step within the enrollment process through the DXC Benefit Center) to compare and choose your health plan options based on your health care needs, cost preferences, how deductibles work, your prescription drugs and your preferred providers. It can help match you to the best medical plan option for you and your family.	N/A
Insurance Carriers	Access the insurance carriers' **preview websites** to find out if your preferred providers (e.g., doctors, hospitals) participate in the carriers' networks. You can also check how prescription drugs are covered under the carriers' drug lists (e.g., formulary) and review other resources available through each carrier.		Once you're a member, take advantage of all the tools, resources and information offered through your **insurance carrier**. For questions about your coverage, always start with your carrier. They know their plans best and have the final authority on all claims, billing disputes, etc.
DXC Benefits Center **Online through the DXC Benefits Center enrollment portal** **By phone at 1.877.627.4015, 8 a.m. to 8 p.m. ET, Monday - Friday**	Access your current, personalized coverage details and manage your benefits.	Compare your options, find your costs, get helpful decision support and enroll. If you have questions, call the DXC Benefits Center. If you don't connect with a representative right away, you can save your place in line and be called back once a representative is available. On the website, you can schedule an appointment to have someone from the DXC Benefits Center contact you (select the "Schedule time with a Representative" tile).	Access your personalized coverage details and manage your benefits throughout the year. You can also complete the evidence of insurability (EOI) process, if required.
Health Pro Advocates (Alight Solutions)	If you need help with complex benefits coverage and decision-making issues, call 1.800.513.1667 and ask to be connected with a Health Pro. They can help you understand how your benefits work, assist you in finding the most affordable care options and help resolve issues.		

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Medical Options

22. What are my options for medical coverage?

You have several medical plans to choose from: Bronze, Bronze Plus, Silver, Gold and Platinum. Each medical plan option includes prescription drug coverage.

Each medical plan is available from multiple insurance carriers at different costs. When you enroll, you'll be able to compare benefits and features across your medical options. Use the Help Me Choose tool (a step within the enrollment process through the DXC Benefit Center) to compare and choose your medical options based on your health care needs, cost preferences, how deductibles work, your medications and your preferred providers. It can help match you to the best medical plan option for you and your family.

For details, see the **Reference Guide**. If you live in California, your options differ as noted below.

23. What happens if I move from a Gold or Platinum medical option to a Bronze, Bronze Plus or Silver medical option and have expenses early in the plan year?

If you enroll in one of the HDHP options, you should be prepared to pay up to the cost of your deductible in case you have significant medical expenses shortly after the plan year begins. See **FAQ 43** for details about how deductibles work.

Even if you start contributing to an HSA right away, your HSA may not yet have enough money to cover costly services early in the year. One option is to pay for those early qualified expenses out of pocket and then, when your account balance grows enough to cover the expense, reimburse yourself from your HSA. This is a good reason to make sure you're saving enough in an HSA. You might also consider the health protection plan options—hospital indemnity, critical care and accident insurance. See **FAQ 47** about the DXC Healthy Behaviors wellness program.

24. I live in California. Are my medical options different?

If you reside in California, your options are different, depending on the carrier you choose:

California (CA) Carriers	BRONZE	BRONZE PLUS	SILVER	GOLD I/II	PLATINUM
Aetna	PPO/POS	PPO/POS	PPO/POS	PPO/POS	PPO/POS
Anthem	EPO	EPO	EPO	EPO	EPO
Cigna	PPO/POS	PPO/POS	PPO/POS	PPO/POS	HMO
Health Net—Northern CA	PPO/POS	PPO/POS	PPO/POS	HMO	PPO/POS
Health Net—Southern CA	PPO/POS	PPO/POS	PPO/POS	HMO	PPO/POS
Kaiser (CA)	HMO	HMO	HMO	HMO	HMO
UnitedHealthcare	PPO/POS	PPO/POS	PPO/POS	PPO/POS	PPO/POS

- **PPO/POS:** Offers both in- and out-of-network coverage. You may need a referral to see a specialist. Check with the carrier for specific requirements.
- **EPO/HMO:** Offers in-network coverage only. Usually requires a referral to see a specialist. Check with the carrier for specific requirements.

California-based carriers, Kaiser and Health Net, offer slightly different versions of Bronze Plus and Silver medical options for employees covering dependents. Employees covering just themselves have the standard Bronze Plus and Silver options.

Review each option carefully as the deductible and maximum out-of-pocket amounts differ and work differently. See the **Reference Guide** for deductible amounts and **FAQ 43** for details about how deductibles work.

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25. Why do employees in California have different plans?

There are marketplace and regulatory differences that are unique to California:

- HMOs are more popular in California, where Kaiser Permanente and Health Net are major carriers. To be able to offer the most popular regional carriers and plans, the carriers were allowed to choose whether to offer their plans as HMOs or PPOs and an alternative Gold HMO design was developed.
- In addition, California has regulations that affect plans offered in California by carriers that are also based there, such as Kaiser and Health Net. These regulations require the use of traditional or "embedded" deductibles and out-of-pocket maximums. To comply with those requirements and still meet the IRS definition of an HDHP, Kaiser and Health Net have some minor differences in their Bronze Plus and Silver plans when covering dependents.

26. I live outside the carriers' service area. How are my medical options different?

Your specific options are based on your home zip code. If you live outside the service areas of all the insurance carriers, you can choose an out-of-area option at the Silver medical plan. Aetna is the insurance carrier.

27. What happens if I move during the plan year?

Your plan and carrier options are driven by your residential address of record. If your carrier is available in your new location, you keep those elections. If your carrier is not available (for example, Kaiser is not available in all parts of the country), your coverage terminates and you need to make a new election. Even if your plan is still available to you, your cost may be different and the plan may use a different provider network in your new location. You can access the **interactive pricing tool** to see plans available and their cost for the region you are moving to. You'll need to enter the access code provided in the 2023 Benefits Annual Enrollment email you receive in early November.

28. What's the difference between a traditional PPO and a high-deductible PPO?

The primary difference is whether you pay more now for coverage you might not need (traditional PPO) or pay less now and pay more later only if you need health care (high-deductible PPO).

A PPO or "preferred provider organization" uses a network of physicians, hospitals and other health care providers that have agreed to provide care at negotiated prices. You can also go to out-of-network providers, but you'll pay more. If you live in California, see the previous page for your plan differences.

In a traditional PPO, like the Gold or Platinum options, basic office visits and specialist visits usually require a copay but don't require that you satisfy your annual deductible. You pay for most other covered services until you meet your annual deductible. After reaching your deductible, you share a fixed percentage of your medical costs with the insurance carrier through coinsurance. If you reach an out-of-pocket maximum in a calendar year, 100% of your eligible medical expenses is covered for the remainder of the year. A traditional PPO costs more because you have access to low-cost services without having to satisfy a deductible.

A high-deductible PPO, such as the Bronze, Bronze Plus or Silver option, is also a type of PPO, but as the name suggests, you have a higher deductible, which must be satisfied before your medical and prescription drug coverage kicks in. To balance the cost of the high deductible, you pay less each paycheck. Once you meet your deductible, you get the benefits of the PPO network negotiated rates but pay a percentage of your ongoing expenses, up to the out-of-pocket maximum. See **FAQ 43** for details about how deductibles work.

29. Is one medical plan better than another?

No, one medical plan isn't better than another. They're designed to give you options so that you can find the plan that makes the most sense for your needs. Take your total costs into consideration—what you pay out of your paycheck (premium cost to purchase coverage) and what you pay out of your pocket when you get medical care (deductibles, coinsurance, copays).

For example, the Gold and Platinum medical plans cost you more each paycheck but less when you receive care. These medical plans have copays for some services and lower deductibles compared with the Bronze, Bronze Plus and Silver medical plans.

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The Bronze, Bronze Plus and Silver medical plans come with lower paycheck costs and higher deductibles. They also provide the opportunity to earn incentives in the form of company contributions to a Health Savings Account (HSA) for participating in the DXC Healthy Behaviors Wellness program. If you don't need a lot of medical care, you'll spend less overall because you're not paying premiums for coverage you don't need.

30. Can each family member choose a different medical plan or insurance carrier?

No. All family members must be enrolled in the same medical plan with the same insurance carrier.

31. Which medical insurance carriers can I choose from?

Most of the largest insurance carriers are participating in the exchange. Keep in mind that the availability of carriers varies by region. Your specific options are based on where you live. You'll be able to see the options available to you when you enroll.

- **Aetna**
- **Anthem Blue Cross and Blue Shield**
- **Cigna**
- **Dean/Prevea360 (Wisconsin)**
- **Geisinger (parts of Pennsylvania)**
- **Health Net (California)**
- **Kaiser Permanente**
- **Medical Mutual of Ohio (Ohio)**
- **Priority Health (parts of Michigan)**
- **UnitedHealthcare**
- **UPMC Health Plan (Pittsburgh)**

Before you are a member, visit the insurance carrier's **preview website** to learn about their services, networks and more. Once you are a member, register for and log on to the carrier's **main website** for personalized information.

When you enroll through the **DXC Benefits Center enrollment portal**, you can see how other people have rated the insurance carriers on a variety of measures, such as customer service, network of providers and online experience. These consumer ratings and comments can help you with your choices.

32. Can I use the same providers as I do today?

It depends. Each insurance carrier has its own network of preferred providers (e.g., doctors, specialists, hospitals) and if you live in California, the network could vary by medical plan. If you want to keep seeing your current doctors, select an insurance carrier that includes your preferred providers in its network. If you are comfortable changing doctors, select an insurance carrier whose network includes providers critical to your care.

Even if you can keep your current insurance carrier through the exchange, the provider network could be different and can change, so always check the provider directories before making a decision. In addition, providers may move in and out of networks throughout the year so always verify your provider is still in network before seeking services.

Do not rely on your provider's office to know the carriers' network(s). To confirm your doctor is in network:

- Check the provider directory on the insurance carrier's **preview website**. Follow the instructions on the preview site to make sure you are searching for providers in the exchange network.
- When you enroll through the **DXC Benefits Center enrollment portal**, check the networks of each insurance carrier you're considering. For the best results:
  - Search for your provider by name, not by medical practice.
  - Check only the office location(s) you are willing to visit.
  - When searching for a facility, use the complete facility name and confirm whether the specialty of the facility is covered in-network.

Important! If you have any uncertainty (for instance, covering out-of-area dependents) or you need the network name, call the insurance carrier.

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33. My doctor's office says they participate in my carrier's network—so I don't need to check, right?

Carrier networks can be complicated and confusing. Carriers generally have multiple networks, each with different levels of discounts and may have different providers participating in each network. A particular doctor might participate in some but not all of a particular insurance carrier's networks. It's best to confirm which of your carrier's specific networks your medical plan uses and which network your doctor participates in. You can do that either by asking your doctor's office or using the provider look-up tool on the carrier's **preview website**—or both. If your provider is not participating in the plan you are enrolled in, you are subject to out-of-network benefits.

34. Why should I use in-network providers?

Seeing out-of-network providers typically costs you substantially more than seeing in-network providers. In addition to paying a higher deductible and higher coinsurance, you must pay the entire amount of the out-of-network provider's charge that exceeds the maximum allowed amount, *even after you've reached your annual out-of-network out-of-pocket maximum*. Certain Platinum and Gold II options won't cover out-of-network services at all.

35. Am I required to designate a primary care physician (PCP)?

If you elect an HMO or EPO option with in-network benefits only, you may need to designate a primary care physician. Check with your particular carrier for PCP requirements.

36. How should I choose a medical insurance carrier if my dependents and I live in different states?

Because you and your dependents must enroll in the same option, you may want to consider one of the national insurance carriers that offers national provider networks, so that your dependents have access to in-network providers in most locations. Regional insurance carriers *may* offer in-network coverage outside of their regional service area through partnerships with other carriers. Contact the insurance carrier for details.

Do not rely on your provider's office to know the carriers' network(s). You need to call the insurance carrier to confirm whether an out-of-area provider participates in a carrier's network.

37. How do I decide which medical plan is right for me?

When thinking about the cost of plans, it's important to do the math. While a high deductible can look intimidating, you need to look at your total out-of-pocket costs and cost exposure—payroll contributions, deductible and annual out-of-pocket maximum (which includes the deductible). If you enroll in a high-deductible health plan—Bronze, Bronze Plus or Silver—you can earn company contributions to a Health Savings Account (HSA) for completing certain wellness activities, which you can use toward deductible expenses or save for future years. If you enroll in a Gold or Platinum plan, you might have a lower deductible, but you won't be eligible for wellness incentives and you'll pay more in payroll contributions, which you can't get back if you end up not using a lot of health care.

Use the **interactive pricing tool** to compare the net costs of the options available to you (enter the access code in the 2023 Benefits Annual Enrollment preview email you receive in early November). Prices shown are your cost (total premium less DXC credit). It does *not* factor in any wellness incentives you might earn if you enroll in a Bronze, Bronze Plus or Silver medical option.

When you enroll through the **DXC Benefits Center enrollment portal**, you can use the Help Me Choose tool, which gives you personalized health plan suggestions based on your health care needs, cost preferences, how deductibles work, your medications and your preferred providers.

If you need additional help selecting a medical option, call the DXC Benefits Center at **1.877.627.4015** 8 a.m. to 8 p.m. ET, Monday through Friday, during Benefits Annual Enrollment. If you don't connect with a representative right away, you can save your place in line and be called back once a representative is available. Alternatively, you can schedule an appointment to have someone from the DXC Benefits Center contact you—log in to the **DXC Benefits Center enrollment portal** and click on the *Schedule time with a Rep* tile. You can also call the **insurance carriers** with specific questions about the medical plan options they offer.

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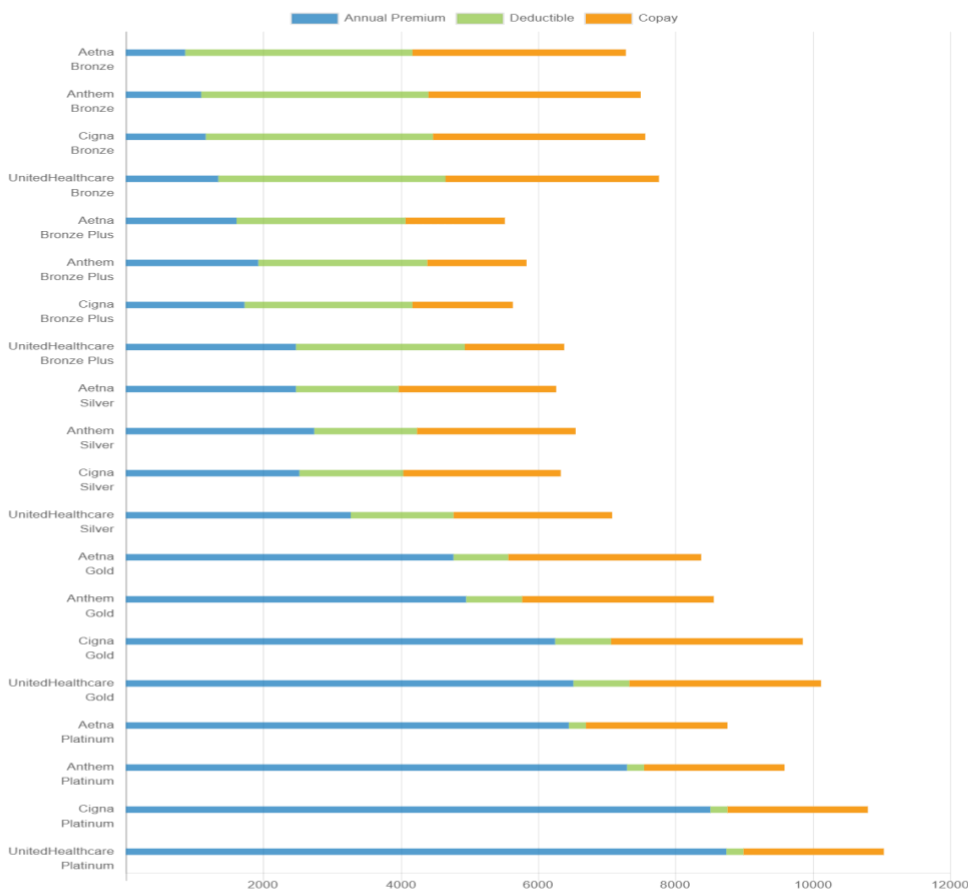
38. How can the interactive pricing tool help me "do the math?"

In the interactive pricing tool, select the *Cost Summary* tab:

A set of bar graphs will appear showing total potential costs* for each plan and the components of that cost (assuming you use in-network providers)—annual employee contributions, deductible and maximum out-of-pocket (not reflecting any wellness incentive you may be able to earn):



**This screen shot is for illustrative purposes only. It is from a prior plan year, as the 2023 interactive pricing tool was not ready at the time these FAQs were prepared. Your costs will also be different based on the region you live in and your salary.*

In this example, the payroll deductions (blue bars) for each Gold and Platinum medical plan are generally greater than the payroll deductions plus deductible (blue bars + green bars) for each Bronze, Bronze Plus and Silver medical plan—illustrating that the total financial exposure for each Gold or Platinum medical plan is significantly greater than that of any Bronze Plus or Silver medical plan.

The tool does not factor in that if you enroll in a Bronze, Bronze Plus or Silver medical plan, you can earn company contributions to an HSA account through the wellness program (up to $950 with Employee coverage, up to $1,500 if covering dependents), which you can use toward your deductible and other out-of-pocket expenses.

This is just an example and is based on using in-network providers. Your results may vary.

Check with the carriers regarding coverage of any prescription drugs you are taking.

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39. Are pre-existing conditions covered?

Yes. When you enroll in medical coverage through the exchange, coverage is guaranteed, regardless of whether you and/or your eligible dependents have pre-existing conditions.

40. What's included in the preventive care that's covered at 100% by all medical plan options?

The U.S. Preventive Services Task Force recommendations are used to determine which services are considered preventive services. In general, the following outpatient preventive care services are 100% paid by the insurance carrier when you see an in-network provider, without needing to meet the deductible. Limitations vary by carrier, so check with your insurance carrier if you have any questions.

Examples of preventive care that could be covered at 100% include:

- Annual physical exam
- Pediatric exam
- Well-woman exam (includes Pap test)
- Mammogram
- Bone density screening
- Cancer screenings
- Cardiovascular screenings
- Colorectal screening
- Prostate screening
- Digital rectal exam
- High blood pressure screening (adult)
- Depression screening (adolescent)
- Depression screening (adult)
- Diabetes screening
- Immunizations (child)
- Immunizations (adult)
- Influenza, shingles and pneumonia vaccinations (adult)

41. How are prescription drugs covered?

Your prescription drug coverage is provided through your medical plan carrier's pharmacy benefit manager—which could be a separate prescription drug company. Each pharmacy benefit manager has its own rules about how prescription drugs are covered. That's why you need to do your homework to determine how your medications will be covered before choosing an insurance carrier.

If you or a covered family member regularly takes medication, call the medical plan carrier before you enroll and use the Help Me Choose tool when you enroll to better understand how your particular prescription drug(s) will be covered. Do not assume that your generic or brand name medication will be covered the same way by each carrier each year. See the **Prescription Drug Transition Worksheet** for questions to ask.

42. What do I pay when I need medical care?

Other than preventive care, which is paid 100%, how much you have to pay when you need medical care primarily depends on the medical plan option you chose. For details, see the **Reference Guide**.

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43. What is a deductible and how does it work?

The deductible is what you pay out of your own pocket before your insurance carrier begins to pay a share of your costs. If you have a deductible, you pay the full “negotiated” costs of all in-network services until you meet your deductible. The “negotiated” costs are the payments that providers (doctors, hospitals, labs, etc.) have agreed to accept from the insurance carrier for providing a particular service. See **FAQ 23** for information about enrolling in a Bronze, Bronze Plus or Silver medical plan option and covering expenses early in the plan year.

The annual deductible doesn’t include copays or amounts taken out of your paycheck for health coverage.

How the medical deductible works depends on the medical plan option you are enrolled in. The standard U.S. plan deductibles work as follows:

- **The Bronze, Gold and Platinum medical plans have a traditional (aka “embedded”) deductible.** Once a covered family member meets the individual deductible, your insurance begins paying benefits for that family member. Charges for all other covered family members continue to count toward the family deductible. Once the family deductible is met, your insurance pays benefits for all covered family members.
- **The Bronze Plus and Silver medical plans have a “true family deductible.”** This means that the entire family deductible must be met before your insurance pays benefits for any covered family members. There is no “individual deductible” in these medical plans when you have family coverage (except in California; see comment below). In these plans, the individual deductible applies only if you cover just yourself. If you choose to cover any dependents, you must satisfy the family deductible before coinsurance kicks in, even if only one family member has expenses.

If you reside in California and cover dependents, the Bronze Plus and Silver medical plans offered by Kaiser and Health Net have traditional “embedded” deductibles, which are not the same as the individual deductibles.

Do you use out-of-network providers? Out-of-network charges do *not* count toward your in-network annual deductible. They only count toward your out-of-network deductible.

44. What’s an out-of-pocket maximum and how does it work?

The annual out-of-pocket maximum is the most you and your covered family members would have to pay in a year for health care costs. The annual out-of-pocket maximum doesn’t include amounts taken out of your paycheck for health coverage, certain copays under the Gold and Platinum medical plans, balance-billed charges or noncovered charges.

How the medical out-of-pocket maximum works depends on the medical plan option you choose:

- **The Bronze, Gold and Platinum medical plans have a traditional out-of-pocket maximum**. Once a covered family member meets the *individual* out-of-pocket maximum, your insurance pays the full cost of covered charges for that family member. Charges for all other covered family members continue to count toward the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, your insurance pays the full cost of covered charges for all covered family members.
- **The Bronze Plus and Silver medical plans have a “true family out-of-pocket maximum.”** This means that the entire family out-of-pocket maximum must be met before your insurance pays the full cost of covered charges for any covered family member. There is no “individual out-of-pocket maximum” in these options when you have family coverage.

Note: If you reside in California and cover dependents, the Bronze Plus and Silver medical plans offered by Kaiser and Health Net have traditional “embedded” annual out-of-pocket maximums.

Do you use out-of-network providers? Out-of-network charges do *not* count toward your in-network annual out-of-pocket maximum; they only count toward your out-of-network out-of-pocket maximum.

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45. What is "prior review" and when is it required?

Before receiving certain types of care, you or your doctor may be required to run it by your insurance carrier first. Getting "prior review" (also referred to as prior authorization or precertification) allows the carrier to make sure you're eligible for the services, ensure you're getting care that makes sense for your condition and confirm how the bill is going to be paid.

Who completes the process depends on where you get care:

- When you stay in network, your doctor usually completes the process on your behalf when it's required. But you should always confirm with your doctor to be sure they are handling it.
- If you go out of network, you are usually responsible for completing the process. You may have to work with your doctor or directly with your insurance carrier to fill out paperwork and receive the appropriate approval before getting care.

When prior review is required and you don't get preapproved, you could get stuck paying *most or all of the bill or a penalty*. Before receiving health care services, always confirm coverage and prior review with the insurance carrier.

46. Will I receive a new ID card for medical and prescription drug coverage?

It depends:

- If you change carriers, you will receive a new card.
- If you stay with the same carrier but change medical plans or coverage tiers, the carriers only issue a new ID card if there was a change to the information displayed on the card. The information displayed on the ID cards varies by carrier, but some common reasons for a new ID card would include:
  - Change of product or network (e.g., PPO to HMO)
  - Change in benefit structure (e.g., deductible, coinsurance)
  - Change in coverage tier (e.g., Employee Only to Family)
  - Change in primary care physician (PCP) (if applicable)

If you are issued a new card, you should receive it before January 1, 2023. If you need care and haven't received your new card, please contact the DXC Benefits Center for assistance.

Healthy Behaviors Wellness Program

47. What is the Healthy Behaviors Wellness program?

The Healthy Behaviors Wellness program is administered by Virgin Pulse and is available to employees who enroll in a DXC high-deductible health plan (HDHP)—the Bronze, Bronze Plus and Silver medical plans.

If you are participating in the Healthy Behaviors Wellness program for the first time in 2023, you will receive a welcome email from Virgin Pulse with instructions on how to enroll.

Wellness incentives are provided in the form of company contributions to a Health Savings Account (HSA). If you enroll in a Bronze, Bronze Plus or Silver medical plan, you must enroll in a 2023 HSA during Benefits Annual Enrollment (even if you enrolled for a 2022 HSA). If you don't want to contribute money from your paycheck, you can select $0 for your contribution election. If you do not have a 2023 DXC-sponsored HSA at the time you earn your wellness incentives, a Health Reimbursement Account (HRA) will be opened for you. See **FAQ 65** to find out if you are eligible for an HSA.

Incentives are generally paid as earned but require a few weeks before they appear in your HSA account.

Activities must be completed and received by Virgin Pulse by the November 30, 2023, deadline to earn associated incentives.

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48. What are the 2023 activities and incentives in the Healthy Behaviors Wellness program?

- **Health Screening:** Complete a biometric screening (e.g., blood pressure, cholesterol, glucose). Only results for screenings that are completed in 2023 and received by the deadline are accepted for incentive purposes.
- **Health Check:** Complete a self-reported online questionnaire.
- **Next Steps Consult:** Complete a call with a Virgin Pulse health coach to review your Health Screening and Health Check results.
- **Virgin Pulse Program Participation:** Education via daily cards, participation in online journeys or wellness coaching via phone, activity tracking, healthy habit tracking, create or participate in wellness challenges.

Available Incentives Paid to Your HSA

	Activity	Employee Only	Employee + Spouse/Domestic Partner, Employee + Child(ren), Family
1	Health Screening	$250	$300
2	Health Check Survey	$70	$70
3	Next Steps Consult	$70	$70
4	Additional Healthy Activities	$560 ($140 per quarter)	$1,060 ($260 per quarter)
Total Annual Incentive Opportunity:		$950	$1,500

There are several ways to complete the health screening, including through a Virgin Pulse partner (i.e., LabCorp and CVS MinuteClinic) or your own physician. If you are newly eligible for the wellness program, you will receive more information about the wellness program, health screenings and how to use Virgin Pulse when the 2023 plan year commences.

49. Why are the wellness program and incentives only available to employees enrolled in an HDHP?

The HDHP medical options take a different approach to plan design, centered around wellness. These plans give members more control and accountability over managing their health and health care spending, so we want to provide members with tools and resources they can use to help with those efforts.

50. Once I complete a wellness activity, how quickly are incentives credited to my HSA?

Depending on when you complete an activity, it can take around 3 to 4 weeks to process incentives and credit them to your HSA. We suggest allowing a little more time for the Health Screening to account for the time it may take the provider who administers the screening to also submit the screening. You should follow up with the doctor’s office to ensure deadlines are met.

Dental Options

51. What are my options for dental coverage?

You have several dental plans to choose from. If you are considering the Platinum plan, please be sure to carefully review the plan rules.

- **Bronze:** A PPO option that covers in- and out-of-network care (note that you’ll receive a discounted rate with in-network providers), but does not cover major services or orthodontic expenses
- **Silver:** A buy-up from the Bronze PPO option that covers in- and out-of-network care (note that you’ll receive a discounted rate with in-network providers), including coverage for major services and, for children up to age 19 orthodontic expenses
- **Gold:** An enhanced PPO option that covers in- and out-of-network care (note that you’ll receive a discounted rate with in-network providers), including coverage for major services and orthodontic expenses for children and adults

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- **Platinum (*research this plan carefully before electing it):*** A dental HMO (DHMO) option that covers **in-network care only**, including orthodontic expenses for children and adults (not available in all areas; confirm the network in your area). Unlike the other dental plans, the Platinum plan features are not standard but vary by carrier. **The networks are very limited, and you must elect a primary care dentist to coordinate all of your dental care**. Although it's called the "Platinum" plan, it is the least expensive option because of these limitations. ***Once you have made your elections, you cannot make changes during the plan year unless you have a qualified change of status.***

Each dental plan is available from different insurance carriers at different costs. When you enroll, you'll be able to compare benefits and features across your dental options.

Remember: Once the enrollment period ends, you cannot make changes to your benefit elections for the new plan year unless you have a **qualified change of status.**

52. Am I required to designate a primary care dentist?

Yes, you are required to designate a primary care dentist to coordinate your care ***if you elect the Platinum dental plan***. If you don't designate a primary care dentist when you enroll, one will be assigned to you. If you do not receive your dental services from your primary care dentist, you are responsible for the entire dental charge. To change your primary care dentist, contact the insurance carrier directly.

You are not required to designate a primary care dentist for the other dental plans.

53. Which dental insurance carriers can I choose from?

You can choose from Aetna, Cigna, Delta Dental, MetLife and UnitedHealthcare. For the Platinum dental plan, eligibility varies by carrier and geography.

Before you are a member, you can visit the insurance carrier's **preview website** to learn about their services, networks and more. Once you are a member, you can register for and log on to the carrier's **main website** for personalized information.

When you enroll through the **DXC Benefits Center enrollment portal**, you can see how other people have rated the insurance carriers on a variety of measures, such as customer service, network of providers and online experience. These consumer ratings and comments can help you with your choices.

54. What do I need to know about dental networks?

Each dental insurance carrier has its own provider networks that can vary by the dental plan you choose. If it's important that you continue using the same dentist, you should check to see whether your dentist is in the network before you choose a carrier.

If you are considering a Platinum dental plan:

- It may cost less than some of the other dental plans, but you ***must*** select a primary care dentist who participates in the insurance carrier's DHMO network and have all of your care coordinated through that dentist. Be sure to check the availability of local in-network dentists before you enroll.
- The Platinum dental plan does not provide out-of-network benefits. So, if you don't use an in-network dentist, you'll pay for the full cost of services.

Do not rely on your provider's office to know the carriers' network(s). To see whether your dentist is in network:

- Check the provider directory on the insurance carrier's **preview website**.
- When you enroll on the **DXC Benefits Center enrollment portal**, check the networks of each insurance carrier you're considering. With most carriers, knowing that your dentist is in the network is a simple way to get the best deal when you need care. However, if you're considering Delta Dental, you need to take it one step further to get the same deal:
  - If you choose a Bronze, Silver or Gold plan, there are actually two Delta Dental networks—PPO and Premier. Although the benefits are the same for both, you may have to pay more if your dentist is only a part of the Premier network. You can save more by seeing a Delta Dental dentist who participates in both the PPO and Premier networks.

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- If you choose a Platinum plan, the Delta Dental DHMO network goes by the name of "DeltaCare," so you need to make sure your dentist is in the DeltaCare network—not just the Delta Dental network.

55. Why is the Platinum dental plan less expensive than other options?

Dentists who participate in the Platinum (DHMO) network are unique because they get paid a set amount per member no matter how often services are used. That gives DHMO dentists an extra reason to keep their patients healthy and control costs. In addition, individuals who enroll in a DHMO are required to select a primary care dentist. Having one dentist coordinate your care also helps to control costs. For these reasons, insurance carriers can often offer DHMOs at lower prices than other options. **The networks can be very narrow—check the network before enrolling in the Platinum plan to ensure you will be satisfied with the availability of dentists.** Remember that once the enrollment period ends, you cannot change your elections for the new plan year unless you have a qualified change of status.

56. Will I receive a new ID card for dental coverage?

If you change carriers, you will receive a new card. If you stay with the same carrier but change dental plan or coverage tier, the carriers only issue a new ID card if there was a change to the information displayed on the card **If you are issued a new card, you should receive it before January 1, 2023.** If you need care and haven't received your new card, please contact the DXC Benefits Center for assistance.

Vision Options

57. What are my options for vision coverage?

You have three vision plans to choose from:

- **Bronze:** Exam-only option that provides in-network discounts for materials (e.g., lenses, frames, contacts)—the benefit provisions for materials vary by carrier, so please check each carrier's plan
- **Silver:** A PPO option that covers in-network and, for certain services, out-of-network care including coverage for materials
- **Gold:** An enhanced PPO option that covers in-network and, for certain services, out-of-network care including coverage for materials

Each vision plan is available from different insurance carriers at different costs. When you enroll, you'll be able to compare benefits and features across your vision options.

58. Which vision insurance carriers can I choose from?

You can choose from EyeMed, MetLife, UnitedHealthcare and VSP.

Before you are a member, visit the insurance carrier's **preview website** to learn about their services, networks and more. Once you are a member, you can register for and log on to the carrier's **main website** for personalized information.

When you enroll through the **DXC Benefits Center enrollment portal**, you can see how other people have rated the insurance carriers on a variety of measures, such as customer service, network of providers and online experience. These consumer ratings and comments can help you with your choices.

59. What do I need to know about vision networks?

Each vision insurance carrier has its own provider network. If it's important that you continue using the same eye doctor or retail store, you should check to see whether your eye doctor or retail store is in the network before you choose a carrier.

Do not rely on your provider's office to know the carriers' network(s). To see whether your eye doctor or retail store is in network:

- Check the provider directory on the insurance carrier's **preview website**.

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- When you enroll through the **DXC Benefits Center enrollment portal**, check the networks of each insurance carrier you're considering.

60. Will I receive an ID card for vision coverage?

No, you will not receive an ID card for vision unless you elect EyeMed. EyeMed is the only vision plan carrier that issues ID cards.

Tax-Favored Accounts (HSAs, HRAs and FSAs)

61. Who administers DXC tax-favored accounts?

Alight Smart-Choice Accounts administers these DXC tax-favored accounts:

- Health Savings Account (HSA) (with UMB Financial Services as custodial bank)
- Health Flexible Spending Account (HC FSA)
- Health Reimbursement Account (HRA) (available in limited circumstances)
- Dependent Care Flexible Spending Account (DC FSA)

YSA administers the Commuter Reimbursement Account (CRA).

62. What are "qualified expenses"?

Qualified expenses include expenses that are considered deductible expenses under IRS rules.

In the case of health expenses, these include unreimbursed out-of-pocket expenses such as copays and coinsurance for medical, dental and vision services. You can also use your Health FSA or HSA funds to buy over-the-counter medications without a prescription, like Tylenol and other pain relievers, heartburn medications, allergy relief, menstrual care and more. For a list of qualified health expenses, please refer to IRS Publication 502, *Medical and Dental Expenses*. Also refer to IRS Publication 969, *Health Savings Accounts and Other Tax-favored Health Plans*.

For information about qualified child and dependent care expenses, refer to IRS Publication 503, *Child and Dependent Care Expenses*.

And for information about qualified commuting expenses, refer to IRS Publication 15-B, *Employer's Tax Guide to Fringe Benefits.*

63. What's a Health Savings Account (HSA)?

An HSA is a special bank account that you can use when you enroll in a high-deductible health plan (HDHP) option such as the Bronze, Bronze Plus or Silver medical plan. It allows you to set aside money on a pre-tax basis to pay for qualified health care expenses, like your medical, dental and vision copays, deductibles and coinsurance. Because you'll be responsible for 100% of your medical and prescription drug expenses until you meet your deductible in the Bronze, Bronze Plus or Silver medical plan, an HSA is a great way to pay less for those out-of-pocket expenses because you're using tax-free money.

Just make sure you use money in your HSA only for qualified health care expenses. If you use money in your HSA for unqualified expenses, you'll pay income taxes on that money and an additional 20% penalty tax if you're under age 65. Keep careful records of your health care expenses and withdrawals from your HSA, in case you ever need to provide proof that your expenses were qualified.

64. Why would I want to open an HSA?

An HSA lets you set aside money on a pre-tax basis to pay for qualified health care expenses, like your medical, dental and vision copays, deductibles and coinsurance. You decide how much money you want to contribute and you can change your contribution election at any time. Once you contribute money to an HSA, the money is yours. Unlike a flexible spending account (FSA) and health reimbursement account (HRA), your balance rolls over from year to year and you can take it with you if you leave the company or retire.

The HSA has the following advantages:

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- Your contributions to an HSA are tax-free, meaning that they are deducted from your paycheck before taxes are taken out.
- Your HSA balance earns interest and those interest earnings are not taxed.
- If your balance exceeds $1,000, you can invest the amount above $1,000 and your investment returns are not taxed.
- You are not taxed on the HSA dollars when you use them to pay eligible expenses.

You can decide whether to enroll in an HSA and how much (if any) money you want to contribute from your paycheck. Even if you don't make any payroll contributions to an HSA, you can still earn wellness incentives and begin to build an HSA balance. Remember, your HSA balance is your money, which means it stays in your account year to year and earn tax-free interest. If you have questions about the use and appropriateness of an HSA as it applies to your specific situation, you should consult a tax professional.

Also, if you enroll in the Bronze, Bronze Plus or Silver medical plan, *you are eligible to earn company contributions to your HSA* if you complete certain wellness activities through the Healthy Behaviors Wellness program (see **FAQ 47**).

65. Who is eligible to open an HSA?

To be eligible to enroll in an HSA and make contributions, you must be enrolled in a company-sponsored high-deductible health plan (HDHP) and (per IRS rules):

- Not be eligible to be claimed as another person's tax dependent, regardless of whether you are actually claimed as a tax dependent; and
- Not be enrolled in any Medicare coverage; and
- Not have any health coverage other than the DXC high-deductible health plan in which you are enrolled, except for certain limited types of coverage described below.

You are not eligible to contribute to an HSA if you are currently covered in another tax-favored health care account, such as a Health Flexible Spending Account (Health FSA) or a Health Reimbursement Account (HRA), including coverage available through a spouse/domestic partner's plan.

You can still be eligible to contribute to an HSA if you have one or more of the following types of health coverages:

- Insurance for a specific disease or illness (such as cancer insurance)
- Accident, disability, dental care, vision care or long-term care insurance
- Drug discount cards
- Insurance that pays a fixed amount per day (or other period) of hospitalization (such as hospital indemnity insurance)
- Most employee assistance programs (such as the DXC LifeManagement Program)
- Disease management programs or wellness programs
- Insurance for liabilities under workers' compensation laws, tort liabilities or liabilities relating to ownership or use of property (such as homeowner or auto insurance)
- A Limited Purpose Health Flexible Spending Account or a Limited Purpose Health Reimbursement Account (typically can be used only for qualified dental and vision expenses)

Finally, because an HSA is an actual bank account in your name, you have to meet the same qualifications as are required for opening a bank account (e.g., the Customer Identification Program or CIP).

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66. What is the Customer Identification Program (CIP)?

Due to the U.S Patriot Act, all banks are required by federal regulation to implement Customer Identification Programs (CIPs) to prevent money laundering and the financing of terrorist operations. Since an HSA is an actual bank account in your name held with UMB, you must pass the CIP process to open an HSA. The following information is sent to UMB in order to fulfill the requirements:

- First and last names
- U.S. residential street address (while a P.O. box may be used as the mailing address, it is not a valid address for the CIP process)
- Date of birth
- Social Security number
- Home or business phone

This information is used to validate the account holder's identity. If anomalies are identified, you may be asked to provide further documentation such as (but not limited to) a driver's license, passport or birth certificate.

67. What is UMB?

UMB Financial Services is one of the premier providers of HSA custodial services. It acts as the custodial bank for HSA accounts administered by Alight Smart-Choice Accounts.

68. What if I fail the CIP process?

The CIP process can sometimes take a couple months. If you ultimately fail, any contributions are returned to you. If you have earned wellness incentives, a Health Reimbursement Account (HRA) is automatically opened on your behalf and the incentives credited there.

69. I want to enroll in a high-deductible health plan, so I can earn wellness incentives, but I am not eligible to open an HSA. What are my options?

If you are ineligible to open an HSA, a Health Reimbursement Account (HRA) is automatically opened on your behalf once you earn any wellness incentives and the funds are credited there. Note that once an HRA has been opened on your behalf, you cannot open an HSA in the same plan year. Also, you cannot make your own contributions to an HRA; and while an HRA balance can roll over from year to year, you can't take it with you if you leave the company.

70. I currently have an HSA with a balance but won't be enrolling in a high-deductible health plan next year. Does this mean I have to forfeit my HSA account or that I can't spend the money?

No. The rule is that you must be enrolled in a high-deductible health plan (HDHP) to open an HSA and make contributions. You do not have to be currently enrolled in an HDHP to spend your account balance on qualified health care expenses.

71. How is an HSA (Health Savings Account) different from a Health Flexible Spending Account (Health FSA) and a Health Reimbursement Account (HRA)?

Although they may sound familiar and all offer certain tax-advantages, there are some important differences in these account options. Make sure you understand how they work before enrolling in them—see the **Health Accounts Comparison Chart** for details.

72. If I'm enrolled in a high-deductible health plan (HDHP), am I able to open a Health FSA?

Yes, you can open a "limited purpose" Health FSA if you enroll in the Bronze, Bronze Plus or Silver medical plans. A limited purpose Health FSA can only be used to pay for eligible dental and vision expenses. Once you meet the medical deductible, then it can be used toward eligible medical and prescription drug expenses as well.

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73. Can I contribute to an HSA if I am covered under my spouse/domestic partner's general-purpose Health FSA?

No. If your spouse/domestic partner is enrolled in a general-purpose Health FSA, your medical expenses would be eligible for reimbursement—so it would be considered other health coverage and you would not be eligible to contribute to an HSA.

74. Can I keep my HSA through DXC if I *don't* enroll in a high-deductible health plan (HDHP) for 2022?

Yes, you can keep the funds, but the account converts to a retail account and you are assessed a monthly fee. Once you open an HSA, you never lose the funds.[1] So, while you must be enrolled in a high-deductible health plan to open an HSA and contribute, you do not have to be enrolled in a HDHP to use the funds in your existing account.

If you currently have an HSA with DXC and you have money left over at year-end, the unspent funds remain in your HSA, earn tax-free interest and are available for qualified health care expenses at any time in the future. However, keep in mind that if you are not enrolled in a DXC HDHP for 2023, your account remains with UMB, converts to an individual account and accrues maintenance charges.

[1]By transferring funds into an HSA investment account, you can potentially benefit from capital appreciation in the value of fund holdings. However, you will also be exposed to a number of risks, including the loss of principal. You should always read the prospectuses for the funds you intend on purchasing to familiarize yourself with these risks.

75. I'm not enrolling in an HDHP for 2023. Do I have to leave my HSA money at UMB and pay the fees?

No. Many retail banks or credit unions allow you to set up an individual HSA account and sometimes waive the fees if you do a certain amount of banking there. You can then roll over funds from other HSA accounts into the HSA account with your personal bank. Keep in mind that you must be enrolled in a high-deductible health plan and meet other eligibility requirements outlined above to be able to contribute additional funds to this HSA.

Likewise, if you leave DXC and establish an HSA with a future employer, you may be able to roll over the funds from the account you established at DXC to the account you establish with your new employer.

76. I currently have money in another, non-DXC HSA from a prior employer. Can I roll that money over into my DXC HSA?

Yes. Please contact Alight Smart-Choice Accounts once your 2023 HSA has been opened for details.

77. What are the 2023 contribution limits for flexible spending accounts (FSAs)?

The DXC 2023 contribution limits are $3,050 for a Health FSA and $5,000 for a Dependent Care FSA.

78. If I don't use all my Health FSA money by December 31, 2022, can I roll it over?

You can roll over up to $570 in unused funds from 2022 to 2023.

79. If I don't use all my Dependent Care FSA money by December 31, 2022, can I roll it over?

While you have until March 31, 2023 to submit Dependent Care FSA claims for the 2022 plan year, you must incur all eligible expenses by December 31, 2022. If you have funds left over at the end of the 2022 plan year, you cannot use them to get reimbursed for 2023 claims, as unused funds are forfeited (i.e., use it or lose it).

80. What is a commuter reimbursement account?

The commuter reimbursement account lets you pay for qualified commuter and parking expenses with pre-tax dollars, including:

- Up to $300 per month for public transport (e.g., mass rail, bus, commuter van); and
- Up to $300 per month for parking near work.

Tolls are not an eligible expense. You can participate in the commuter reimbursement account at any time. For qualified commuting expenses, see IRS Publication 15-B, *Employer's Tax Guide to Fringe Benefits*.

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Paying for Coverage

81. Does DXC pay for part of the cost of my health benefits?

Yes. DXC shares in the cost of medical and dental benefits. DXC's contribution appears as credits to you when you review your medical and dental plans in the **DXC Benefits Center enrollment portal**.

For medical, the amount of credit varies based on your geographic region, salary and coverage tier (e.g., Employee only, Family, etc.). You can apply the credit toward the cost of whichever medical plan you choose. You are then responsible for the balance.

For dental, the credit varies based on the coverage tier you choose (e.g., Employee only, Family, etc.).

You pay the full cost of vision benefits.

82. Why does the medical credit vary based on geographic region?

In the exchange, carriers price their medical insurance plans based on 22 geographic regions to better reflect the regional differences in health risk and health care costs. DXC takes these premium differences into account when setting subsidies—an employee in a higher cost premium area receives more credit than a similar employee in a lower cost premium area.

Dental premiums and vision premiums are set on a national basis—there is no geographic variance.

83. Why does the medical credit vary based on salary?

DXC is committed to offering health care options that are accessible to employees regardless of salary. Salary-based contributions are consistent with a growing practice among large companies. To ensure our health plans are accessible to all, DXC currently has set subsidies based on three salary bands.

Band	Salary Range
1	<$70,000
2	$70,000 - $89,999
3	≥$90,000

84. What if my salary changes during the plan year?

Your medical credit for the 2023 plan year is based on your salary at annual enrollment. The cost of supplemental life, supplemental AD&D, short- and long-term disability increases as your salary increases because the benefits paid are salary based.

Your medical credit could change if you move to another geographic pricing region or change coverage tiers due to a life event.

85. When can I find out the cost of coverage?

During Benefits Annual Enrollment, you can see the credit amount from DXC and your price options when you enroll through the **DXC Benefits Center enrollment portal**.

Meanwhile, you can access the interactive pricing tool to see your net costs (carrier premium less DXC credit) for your options (see **FAQs 37 and 38**).

86. Do I get to keep the DXC credit if I don't enroll in coverage?

No. The credit you get from DXC is for the medical and dental coverage you purchase through the exchange.

87. Is there a tobacco use surcharge or working spouse/domestic partner surcharge for medical benefits in 2023?

Yes, these surcharges apply in 2023.

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All DXC employees electing to participate in a DXC medical plan must attest that they have been tobacco-free for the preceding 6 months.

If you cannot attest to your tobacco-free status, you are charged an additional *$10 per week* for medical coverage during the 2023 plan year. You can have the surcharge suspended during the year and be reimbursed retroactively if you truthfully attest to either of the following:

- You have been tobacco-free for the preceding 6 months; or
- You have completed participation in a company-sponsored tobacco cessation program (e.g., Magellan or your medical plan).

If you enroll in a DXC medical plan and cover a spouse/domestic partner, you must attest that your covered spouse/domestic partner is not offered medical benefits from their employer. If you cannot or do not attest, you are charged an additional *$25 per week* for medical coverage during 2023. You must promptly report any changes in status, as working spouse/domestic partner surcharges are not reimbursed retroactively.

Changing Benefit Elections

88. Can I change my benefit elections outside of Benefits Annual Enrollment?

Generally, no. Any benefit elections you make during your initial eligibility period or during an annual enrollment period, including default elections, generally cannot be changed until the next Benefits Annual Enrollment unless you:

- Are entitled to Special Enrollment Rights; or
- Have a Qualified Change of Status; or
- Request Other Permitted Election Changes, as detailed below.

You are permitted to change your contribution elections under the HSA and the commuter reimbursement account on a prospective basis, as described below.

Special Enrollment Rights

You are entitled to special enrollment rights that permit you to change your enrollment outside the initial eligibility period and annual enrollment period, in one of the following circumstances:

- If you add a new eligible dependent through marriage, birth or placement for adoption, you may enroll yourself and your new dependent(s) or change health plans, as long as the request is made within 30 days of the event and documentation is received in a timely manner.
- If you currently have Medicaid or Children's Health Insurance Program (CHIP) coverage, but lose this coverage because you are no longer eligible, you have 60 days from the date of the Medicaid/CHIP eligibility change to request enrollment in the DXC group health plan.
- If you become eligible for a state's premium assistance program under Medicaid or CHIP, you have 60 days from the date of the Medicaid/CHIP eligibility change to request disenrollment from the DXC group health plan.
- If you declined enrollment for yourself or your eligible dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in DXC health plan coverage if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 30 days after the other coverage ends. The loss of other health insurance coverage qualifies for special enrollment treatment only if you satisfy both of the following conditions:
    - The affected person was covered under another group health plan or health insurance coverage when coverage under the DXC plan was originally offered to you and
    - The loss of other coverage was a result of one of the following:
        - Loss of eligibility for or expiration of COBRA coverage that was not due to non-payment or voluntary termination of COBRA coverage; or

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- Loss of other non-COBRA coverage due to loss of eligibility, including loss as a result of legal separation, divorce, death, termination of employment or reduction of hours of employment; or
- Termination or significant change of employer contributions.

Qualified Change of Status

All requests for a change in coverage as a result of a qualified change of status (see tables below) must be registered with the DXC Benefits Center within 30 days of the event date. Supporting documentation for the change must be submitted within 30 calendar days of the date the event was registered with the DXC Benefits Center.

Any change in participation must be:

- Requested within 30 calendar days of the qualified change of status; and
- Consistent with and due to the qualified change of status.

Any request for a change in coverage will not be processed if:

- The request for change in coverage is received more than 30 calendar days after the qualified change of status event; or
- The required documentation is not received within 30 calendar days of the date the change request was received.

Your next opportunity to change your enrollment will be during the next Benefits Annual Enrollment period, unless you have another qualified change of status, are entitled to special enrollment rights or request other permitted election changes as detailed below.

NOTE: The qualified change of status rules outlined here also apply to changes to post-tax coverages, e.g., dependent life insurance, short-term disability and long-term disability coverage.

Qualified Change of Status for Pre-Tax Contributions and Health FSA Participation	
1.	Marriage/domestic partnership, divorce, legal separation, annulment, end of a domestic partnership
2.	Childbirth, adoption or placement for adoption of a child
3.	Death of your eligible dependent
4.	Beginning or end of employment for you or your eligible dependent
5.	Change in the employment status of yourself or your eligible dependent as a result of the following: • A change in status between full-time and part-time worker (and vice versa) • Commencement of or return from an unpaid leave of absence • Commencement or termination of strike or lockout • Any other change in employment status that affects eligibility to receive DXC benefits
6.	Change in residence or worksite for you or your eligible dependent that results in loss of eligibility
7.	Loss of other coverage as a result of one of the following: • Loss of eligibility for or expiration of COBRA coverage that was *not* due to non-payment or voluntary termination of COBRA coverage; or • Loss of other non-COBRA coverage due to loss of eligibility, including loss as a result of legal separation, divorce, death, termination of employment or reduction of hours of employment; or • Termination or significant change of employer contributions
8.	Your spouse/domestic partner or your eligible dependent becomes eligible for coverage
9.	Compliance with a judgment, decree or order relating to medical or dental coverage for a child resulting from a divorce, annulment or legal separation, including a Qualified Medical Child Support Order (QMCSO)
10.	You or your eligible dependent loses entitlement to Medicare/Medicaid
11.	Significant change in cost of coverage (either increase or decrease)
12.	Your eligible dependent is no longer eligible due to attainment of limiting age

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Qualified Change of Status: Dependent Care FSA (Initiate or terminate participation, increase or decrease contributions)	
1.	Marriage/domestic partnership, divorce, legal separation, annulment, end of a domestic partnership
2.	Childbirth, adoption or placement of a child for adoption
3.	Death of your eligible dependent
4.	Spouse/domestic partner employment begins or ends, hours increase or decrease; or loses Dependent Care assistance through employer
5.	Change in your eligible dependent's eligibility as a dependent under the plan
6.	Significant change in the cost of Dependent Care (increase or decrease)

Other Permitted Election Changes

You may also make a prospective election change under the following circumstances:

- **Other Plan:** You may make a prospective election change that is due to and consistent with a change made under your DXC Technology Company Cafeteria Program Eligible Dependents plan from their employer (including another DXC plan) if:
  - The cafeteria plan or qualified benefits plan of that individual's employer permits participants to make an election change that would otherwise be permitted under proposed or final IRS regulations under Section 125; or
  - That plan's plan year is not a calendar year.
- **Loss of Coverage:** You may make a prospective election change to add medical, dental or vision coverage for yourself or your DXC Technology Company Cafeteria Program Eligible Dependents if any of these individuals loses coverage under any group health plan sponsored by a governmental or educational institution.
- **Compliance:** You may also make an election change to comply with a judgment, decree or order relating to accident/medical or dental coverage for a child resulting from a divorce, annulment or legal separation, including a Qualified Medical Child Support Order (QMCSO).
- **Medicare:** You may prospectively elect to cancel coverage for you or your DXC Technology Company Cafeteria Program Eligible Dependents when the affected person *becomes entitled* to coverage under Medicare or Medicaid. You may also prospectively elect to initiate coverage for you or your DXC Technology Company Cafeteria Program Eligible Dependents when the affected person *loses* eligibility under Medicare or Medicaid.

Any changes made pursuant to this section must be made within 30 calendar days of the event giving rise to the change. Required documentation must be received within 30 calendar days of the date the change was requested.

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These FAQs are intended to provide information about some of the benefits you may be eligible for through DXC Technology Company. Terms for employees covered by the Service Contract Act or a collective bargaining agreement may differ. If there is a discrepancy between the information displayed here and the official plan documents, the plan documents will govern. DXC reserves the right to amend, suspend or terminate the plan(s) or program(s) at any time. This document does not constitute a contract of employment. Please also note that this document is intended to provide high-level information about the most common plan designs offered across insurance carriers. It does not take into account how each insurance carrier covers any state-mandated benefits, its plan administration capabilities or the approval from the state Department of Insurance of the benefits offered by the insurance carrier.

If you have a question not answered here, call the DXC Benefits Center at 1.877.627.4015,
8 a.m. to 8 p.m. ET, Monday through Friday.

Information contained herein is not intended as legal, tax or other professional advice. You should not act upon any such information without first seeking a qualified professional on your specific matter.

Terms and conditions of policies may change. Please consult policy documents to confirm availability of benefits.

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