DXC Employee Benefits Guidebook and Summary Plan Description

2024 Health & Welfare Benefits

For employees on U.S. payroll (including U.S. Territories)

DXC Employee Benefits Guidebook and Summary Plan Description

Effective January 1, 2024

TABLE OF CONTENTS

Section 1

Introduction and Eligibility

Introduction and Eligibility

Introduction

As a DXC Technology Company (DXC) employee, you and your family have a wide range of health and welfare benefits available. Benefits are administered by the DXC Benefits Center, which is managed by Businessolver. This Guidebook provides a summary of some of those health and welfare benefits offered to U.S. employees:

- Medical (including prescription drug)
- Dental
- Vision
- Basic & Supplemental Employee Life Insurance
- Spouse/Child Supplemental Life Insurance
- Basic & Supplemental Accidental Death & Dismemberment Insurance (AD&D)
- Short-Term Disability Insurance (STD)
- Long-Term Disability Insurance (LTD)
- Cafeteria Program (pre-tax contributions, Flexible Spending Accounts (FSAs), Health Savings Accounts (HSAs))

Health Reimbursement Account (HRA)

- Commuter Reimbursement Account
- DXC Healthy Behaviors Wellness Program
- Torchlight Caregiver and Parent Support Services
- Bright Horizons Enhanced Family Supports
- Business Travel Accident Insurance (BTA)
- Voluntary Benefits (Hospital Indemnity, Accident, Critical Illness, Identity Protection, Legal Services, Auto & Home Insurance, Pet Insurance)
- DXC LifeManagement (EmployeeAssistance Plan)
- Other life services

Unless otherwise stated, throughout this Guidebook "U.S." is intended to include U.S. Territories such as Puerto Rico and the U.S. Virgin Islands.

Many of the benefits described in this Guidebook are optional; therefore, it is important that you understand your choices, you enroll within the required period of time, and you understand the consequences of not enrolling within 30 days of your hire date (or initial date of eligibility).

It is your responsibility to read the entire Guidebook and contact the DXC Benefits Center for clarification about any topic that you do not understand.

This Guidebook summarizes certain DXC benefits and policies. It is not intended to confer contractual rights of any kind upon any employee, or to create contractual obligations of any kind for DXC. DXC may elect to maintain these benefits and policies indefinitely. However, as DXC believes necessary or appropriate, its policies, procedures, practices, or benefits may be supplemented, revised, or discontinued at any time, at DXC's sole discretion, with or without notice. The Guidebook is periodically reviewed and updated. As it is not always possible to keep the Guidebook current, you should ask the DXC Benefits Center for current information.

This Guidebook does not contain the complete terms or conditions of any of DXC's current benefit plans and policies; it is meant to provide general explanations. The complete terms and conditions of the employee benefits plans of the company are contained in the formal legal documents that govern the plans and policies.

We have tried to accurately reflect the terms of the applicable group plans, plan documents, and policies. However, in an instance of conflict between this Guidebook and the applicable policy or plan, the plan or policy provisions will govern. When there is a conflict, local, state and/or federal law will govern as applicable.

Employees who are members of a collective bargaining unit are covered by the benefits negotiated in the collective bargaining agreement and not necessarily the benefits discussed in this Guidebook.

Certain groups of employees who transitioned to DXC as a result of an acquisition or contract award may have benefits that were specifically negotiated in the contract. Please refer to the incumbent hire provisions provided at the time of transition or your offer letter for benefits provisions specific to your transition.

To obtain more information on the benefits, programs, and processes listed below, visit the DXC Benefits Center portal at myDXCbenefitscenter.com. For further information about your employment with DXC, you should review the DXC policies available on Employee Connect, which is accessible through the DXC Intranet.

At-Will Employment Relationship

This Guidebook is not contractual and should not be relied upon as a contract. In addition, DXC remains free to change any employment benefit or other condition of employment at any time. It is important that you understand that nothing in this Guidebook constitutes a promise or guarantee as to the terms and conditions of your employment with DXC.

Also, nothing in this Guidebook constitutes a promise or guarantee as to the duration of your employment with DXC. Just as you are free to leave your employment with DXC at any time and for any reason, DXC has the right to terminate your employment at any time, without prior notice, and with or without cause. Rather, our employment relationship is based on the mutual consent of each party and either you or DXC may terminate the relationship at any time. This is known as “at-will employment.”

Employment Classifications & Benefit Eligibility

Benefits eligibility is generally based on an employee’s employment classification.

Employee Classifications

The following information provides a general description of employment classifications. Additional information regarding employee classifications can be found within the **DXC U.S. Employment Classifications Policy**.

Regular Full-time Employee: Works an indefinite period of employment with a regular work schedule of at least 30 hours per week.

Regular Part-time Employee: Works an indefinite period of employment with a regular work schedule of at least 20 hours per week, but fewer than 30 hours.

Limited-term Full-time Employee: Works a defined period of employment of at least 6 consecutive months with a regular work schedule of at least 30 hours per week. (Note: as of January 1, 2018, this classification is closed to new entrants.)

Limited-term Part-time Employee: Works a defined period of employment of at least 6 consecutive months with a regular work schedule of at least 20 hours per week, but fewer than 30 hours. (Note: as of January 1, 2018, this classification is closed to new entrants.)

Temporary Employee: Employees identified to work a short-term scheduled period of employment not to exceed 6 consecutive months. Includes Temporary Full-time, Temporary Part-time, and Temporary University (Intern).

Casual Employee: Regularly works fewer than 20 hours per week; or works only on an as-needed, call-in basis.

Refer to the **DXC U.S. Employment Classification Policy** (available on Employee Connect) for definitions of the various employment classifications, which are also listed in **Section 1, Introduction and Eligibility**. The same provisions apply here.

Summary of Health and Welfare Program Eligibility

DXC offers eligible employees a wide range of benefits, paid and unpaid leaves of absence, and other programs. The following chart is a general summary of health and welfare benefits. For information on time away from work, such as vacation and leaves of absence, please refer to the corresponding policy available on in Employee Connect. Employees covered under a collective bargaining agreement may have different benefits.

Program	Regular (and Limited-term)		Temporary	Casual
	Full-time	Part-time		
Medical (including prescription drug)	✓			
Dental	✓			
Vision	✓			
DXC LifeManagement Program (EAP)	✓	✓		
Life (Basic, Supplemental, Dependent)	✓			
Accidental Death & Dismemberment (Basic, Supplemental)	✓			
Short-term Disability	✓			
Long-term Disability	✓			
Cafeteria Plan (i.e., pre-tax contributions, Flexible Spending Accounts, and Health Savings Accounts)	✓			
Commuter Reimbursement Account	✓	✓[1]	✓[1]	✓[1]
Torchlight Caregiver and Parent Support Services	✓			
Bright Horizons Enhanced Family Supports program s	✓	✓	✓	✓
Perks At Work (discount program)	✓	✓	✓	✓
Business Travel Accident Plan	✓	✓	✓	✓
Voluntary Benefits (Hospital Indemnity, Accident, Critical Illness, Identity Protection, Legal Services, Auto & Home Insurance, Pet Insurance)	✓			

1. Where required by local law

Contact Information

DXC Benefits Center

The DXC Benefits Center is managed by Businessolver. Employees can enroll in benefits at myDXCbenefitscenter.com. Employees can also contact the DXC Benefits Center by calling 1.888.305.5499. Representatives are available Monday through Friday from 8:00 a.m. to 5:00 p.m. Eastern time.

General Information about DXC Benefits

Employees can obtain information and forms, as well as links to health plan provider websites, from myDXCbenefits.com.

DXC HR Support Teams

DXC uses Employee Connect for its global HR help portal. If you have questions about your payroll deductions,personal data, or other questions that cannot be resolved by the DXC Benefits Center, please visit Employee Connect at https://dxchr.service-now.com/hrportal. You'll find resources and information on HR and other employment issues. You can also submit problems and questions through the portal.

Claims, Appeals & Coverage

Please direct all questions regarding claims, appeals, and benefits paid to the appropriate claims administrator for your plan. Contact information is provided in the back of this Guidebook.

Section 2

MEDICAL PLANS

Medical Plans

General Information, Eligibility, & Enrollment

DXC offers medical plans to you and your eligible family members. All plans are administered by the DXC Benefits Center managed by Businessolver.

Employee Eligibility

For convenient reference in this Guidebook, the medical coverage options are described as separate plans. For example, a reference to the “same plan” is a reference to the same medical coverage option. These medical coverage options are provided through a sub-part of the ERISA plan through which other benefits are provided (such as other vision and dental coverage). That ERISA plan is plan number 502.

For a list of employers participating in the ERISA plan of which this medical coverage is a part, see **Section 15, ERISA Information**. Section 15 shows whether a participating employer offers a particular plan to its employees. Not all participating employers offer medical coverage or all of the medical coverage options discussed in this Section 2. Some participating employers only offer certain coverage to certain employee groups. See **Section 15, ERISA Information,** for more information.

You are eligible to enroll in medical coverage on the first day you report to work if you:

- Are on a U.S. payroll; and
- Work for an employer that offers this benefit to its employees (see **Section 15, ERISA Information**); and
- Are a regular full-time employee, or a limited-term full-time employee; and
- Are not covered under a collective bargaining agreement (CBA), unless the agreement specifically includes participation in medical coverage discussed in this Section 2.

In addition to the above eligibility requirements, which apply to many of the component benefits under the ERISA plan referenced above, for eligibility for medical coverage, you may not be enrolled in any other medical plan offered through DXC.

If you do not meet these eligibility requirements on the first day you report to work, but later meet them due to a change in employment status from temporary, casual, or part-time, you will become eligible at that time.

If you are part of a DXC-approved transition group that becomes effective and benefits-eligible on a Saturday, you will be covered on that Saturday instead of the first day you report to work, if the first day you report to work is the Monday immediately following.

The following employees are not eligible for medical coverage:

- Part-time employees (both regular and limited-term)
- Temporary employees
- Casual employees
- Employees on any foreign payroll, including those on a split payroll

Refer to the DXC **U.S. Employment Classification Policy** (available on Employee Connect) for definitions of the various employment classifications, which are also listed in **Section 1, Introduction and Eligibility**. The same provisions apply to this benefit plan.

Family Eligibility for Medical Plans

If you elect employee coverage, you may also elect to cover your eligible family members under the same plan.

Definition of Eligible Family Members:

1. Your legal spouse (same or opposite sex), including common law spouses in states that recognize common law marriage, as long as you are not legally separated. (A “legal separation” is based on a court order that defines legally enforceable rights and obligations of the parties. Merely living apart is not a legal separation.);

2. Your domestic partner (of same or opposite sex) who meets the following criteria (please note that imputed income applies):
   - You and your partner live in a state that has a process to recognize domestic partnerships, civil unions, etc., and you have formalized your relationship through that process; or
   - You live in a state that does not have a process to recognize domestic partners and, therefore, have not formalized your partnership as indicated above. However, all of the criteria below are met:
   - You and your partner are at least age 18; and
   - Neither you nor your partner are legally married to another person of the same or opposite sex or in partnership with another person of the same or opposite sex, and have not been for at least six months; and
   - You and your partner are not related to each other by blood to a degree of closeness that would prohibit marriage in your state of residence; and
   - You and your partner are in an exclusive, committed relationship that is intended to continue indefinitely; and
   - You and your partner share a mutual obligation of support and responsibility for each other’s welfare; and
   - You and your partner currently share a principal residence, have done so for at least six months, and intend to reside together indefinitely; and
   - You must be able to provide 3 of the 8 documentation categories for dependent verification. See the list of documentation categories at mydxcbenefits.com/dependent-verification/.

3. Your children as defined here: An eligible child must meet all of the following criteria to be eligible for coverage under a DXC medical plan:
   a. The child must be under age 26; and
   b. The child must be your child (including an adopted child, stepchild, eligible foster child, and a child for whom a court has appointed you legal guardian):
      i. Adopted child includes a child lawfully placed with you for legal adoption even if the adoption is not final.
      ii. Foster child is any child who is placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

4. Your adult disabled child may continue to be eligible beyond the limiting age (age 26).
   a. An adult disabled child is defined as an unmarried dependent child who:
      i. Is incapable of self-sustaining employment by reason of mental or physical handicap; and
      ii. Continues to be dependent for support and maintenance.
   b. Proof of disabled child Status

i. If the child is eligible for and covered by a DXC plan on the date s/he reaches the limiting age, application/proof of incapacity/disability for continued eligibility/coverage must be provided to the DXC Benefits Center within 30 days of the date that age was reached.
ii. If the child is eligible for but not covered by a DXC plan, and you wish to enroll him or her, evidence of immediate prior coverage must be presented to the DXC Benefits Center when enrollment is requested, and application/proof of incapacity/disability must be provided to the DXC Benefits Center within 30 days of loss of other coverage.
iii. The applicable carrier must review and approve the request for continued eligibility/coverage or the enrollment application/proof of incapacity/disability.
iv. If coverage is approved, as a result of meeting the preceding conditions, eligibility will continue until your adult disabled child is no longer eligible as approved, fails to have the required exams, or your eligibility for coverage ends, whichever occurs first.

Documentation Requirements for Eligible Family Members

DXC reserves the right to request documentation demonstrating the above relationships. The required supporting documentation that DXC may request for each category may include (but is not limited to):

- Spouse:
  - **You must submit one of these documents:**
    - Government-issued marriage certificate
    - Notarized affidavit of common law marriage
    - Government-issued certificate of civil union partnership
- Domestic Partner:
  - A notarized affidavit certifying that your domestic partner meets the domestic partner eligibility requirements and
  - Documentation demonstrating that you and your eligible domestic partner meet at least 3 of the 8 categories below. Documentation must prove:
    - Joint interest in real property, as evidenced by title or mortgage, lease or rental agreement, by you and your partner
    - Joint ownership or purchase of a motor vehicle by you and your partner
    - Joint ownership of a checking, savings, or investment account or joint liability for a loan or credit accounts by you and your partner
    - Your partner is named as primary beneficiary for your company-sponsored life insurance policy
    - Your partner is named as primary beneficiary for your company-sponsored pension plan benefits, company sponsored deferred compensation plan, or company-sponsored 401(k) plan
    - Your partner is named as primary beneficiary in your will
    - Your partner has authority to deal with property owned by you under a valid written power of attorney
    - You have given your partner written authority to make decisions concerning your health and well-being if you are unable to do so

- Biological child: government-issued birth certificate
- Adopted child: government-issued birth certificate or adoption certificate or placement agreement
- Stepchild: government-issued birth certificate AND both documents verifying eligibility for the spouse/domestic partner
- Other child: government-issued birth certificate AND a federal tax return from the last 2 years claiming the child as a dependent
- Disabled child: The applicable document above AND a federal tax return from the last 2 years claiming the child as a dependent

Eligibility Date for New Dependents

If you are unmarried and/or have no eligible family members on the date you begin active employment, your eligible family members are first eligible for medical coverage on the earliest of the:

- Date you marry; or
- Date you become responsible for the support and maintenance of a dependent child as previously described.

Family members must be enrolled within 30 days of first eligibility or during the Benefits Annual Enrollment period (typically held during October/November each year). See **Section 14, DXC Technology Company Cafeteria Program,** under **Changing Your Cafeteria Plan Elections**.

Verification of Eligibility for Family Coverage

New family members seeking eligibility under the Medical plans must provide verification of dependent status. For existing dependents, DXC reserves the right to request at any time verification of:

- Family member eligibility; and/or
- Change of status (e.g., certificates of birth, marriage, adoption).

Such verification may include (but is not limited to) annual eligibility audits and verification of all newly added dependents. Failure to comply with the verification process or to produce the required documentation will result in termination of coverage for the unverified dependent. In the event the terminated dependent is reinstated as the result of an appeal, reinstatement will be prospective from the date of the favorable decision (**not** retroactive to the date coverage was terminated).

Medical Child Support Orders (MCSOs) and Qualified Medical Child Support Orders (QMCSOs)

Medical Child Support Orders (MCSOs) mandate coverage for eligible dependent children. If you are eligible for any health plan available through DXC and you receive an MCSO, it must be mailed, faxed, or emailed to:

DXC Technology Company
Qualified Order Center
Businessolver.com, Inc.
PO Box 850552
Minneapolis, MN 55485-0552

Fax: 1.515.343.2246
Email: qmcso@businessolver.com

You will be notified if DXC receives an MCSO that affects you from any other source.

Any MCSO received will be reviewed to determine if the order is qualified. A Qualified Medical Child Support Order (QMCSO) is an order, decree, judgment, or administrative notice (including a settlement agreement) issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law, which has the force and effect of law in that state, which meets the requirements of Section 609 of ERISA.

If additional information is required, all interested parties will be advised of the specific information necessary to process the MCSO. Once the review is complete, you will be advised regarding its status as a QMCSO.

Enrollment/Effective Date of Coverage

Enrolling in Medical Coverage

You can enroll yourself and eligible family members in medical coverage at one of the following times:

1. Within 30 days of your hire date (or initial date of eligibility);
2. During the Annual Benefits Open Enrollment period; or
3. Within 30-days of a qualified change of status, special enrollment, or a specifically permitted event (all as described in **Section 14, DXC Technology Company Cafeteria Program** under **Changing Your Cafeteria Plan Elections**).

To enroll yourself and your eligible family member(s), you must complete your enrollment online through the DXC Benefits Center portal at (myDXCbenefitscenter.com) or via phone (1.888.305.5499).

The consequences of not enrolling in medical benefits are as follows:

- If you do not enroll within the periods described above, your medical election will default to waiver of coverage.
- If the annual enrollment period requires active enrollment for the following plan year, and you do not enroll, your medical election will default to waiver of coverage.

It is your responsibility to review your remuneration statement (paystub) to confirm deductions accurately reflect your elections.

Your election is irrevocable and binding. Your next opportunity to enroll or make enrollment changes will be during the Annual Benefits Open Enrollment period, unless you have a qualified change of status, are eligible for a special enrollment, or have another specifically permitted event as described in **Section 14, DXC Technology Company Cafeteria Program** under **Changing Your Cafeteria Plan Elections**. The same provisions also apply to this benefit plan.

Effective Date of Coverage

If you are a newly-hired employee, your medical benefits will be effective retroactive to your hire date.

If you are a newly-eligible employee, your medical benefits will be effective retroactive to your initial date of eligibility.

If you are enrolling or changing elections due to a qualified change of status, special enrollment, or specifically permitted event as described in **Section 14, DXC Technology Company Cafeteria Program** under **Changing Your Cafeteria Plan Elections**, your medical benefits will be effective retroactive to the date of your qualifying life event.

If your qualified change of status is the:

- Birth of a child, your medical benefits will be effective retroactive to the child's date of birth
- Adoption of a child, coverage will be effective retroactive to the legal adoption date
- Legal guardianship of a child, coverage will be effective retroactive to the date of the order of guardianship

Annual Benefits Open Enrollment/Changing Your Elections

Annual Benefits Open Enrollment Period

Once each year, you have an opportunity to transfer in or out of your elected medical plan. The Annual Benefits Open Enrollment (Annual Enrollment) period is usually held in October or November, and any new elections have an effective date of January 1 of the new plan year. The elections you make during Annual Enrollment, including default elections, are irrevocable and binding until the next Annual Enrollment period unless you are eligible to change your elections as described in **Section 14,** under **Changing Your Cafeteria Plan Elections**. The same provisions also apply to this benefit plan.

Unless the company communicates otherwise prior to Annual Enrollment, your medical coverage will continue each year as previously elected, but at new plan year prices, unless you make a change during the Annual Enrollment period. This must not be interpreted as a promise or guarantee that the same benefit plans will be available to you from one year to the next. (See **Introduction** on page 1-1, above.)

Changing Your Elections

See **Section 14, DXC Technology Company Cafeteria Program under Changing Your Cafeteria Plan Elections.** The same provisions also apply to this benefit plan.

Cost of Participation in the Plan

Your Contributions

The cost of participating in medical benefits is available on the DXC Benefits Center enrollment portal when you are ready to enroll. Additional surcharges may apply. See **Working Spouse Surcharge** and **Tobacco Use Surcharge**, below.

Pre-Tax Contribution for Medical Coverage

Your contributions for your elected medical coverage will be taken from your gross salary through payroll deductions before federal income taxes are calculated and before state income taxes are calculated (in states where legally permitted). Your pre-tax contributions are governed by and pursuant to the **DXC Technology Company Cafeteria Program ("Cafeteria Program")** described in **Section 14**, which is a pre-tax contribution plan for the benefit plans available pursuant to the Cafeteria Program. Under existing federal law, coverage for eligible family members must be provided on a post-tax basis if your eligible family members do not qualify as dependents for federal tax purposes. See **Special Definitions Regarding Dependents** in Section 14, DXC Technology **Company Cafeteria Program**.

Working Spouse Surcharge

DXC is continually working to keep the cost of medical coverage as low as possible for all employees. To mitigate rising medical costs, a working spouse surcharge may apply.

The working spouse surcharge applies if your spouse is offered medical benefits from his/her own employer, but you choose to cover him/her on your DXC medical plan instead. The surcharge is **$50 biweekly.** This fee is *in addition to your* regular medical benefit deduction. The surcharge applies only to medical plans.

Exemptions: You will not be subject to the surcharge if any of the following apply:

- You are not enrolling your spouse in DXC medical coverage; or
- The spouse you are covering is:
  - Not employed;
  - Employed by DXC or another participating employer in the Plan (see **Plan Sponsor** under **Section 15, ERISA Information)**;
  - Employed, but not eligible for medical benefits from his/her employer; or
  - Employed and eligible for medical benefits from his/her employer, but s/he must pay 100% of the cost.

Note that the following are not considered to be medical benefits from a spouse's employer and therefore will not trigger the working spouse surcharge:

- Retiree medical coverage
- COBRA coverage
- Medicare
- Medicaid

Attestation: When you enroll your spouse in benefits, you will be asked to attest that your spouse is not offered medical benefits from another employer. If you cannot or do not attest, you will be assessed the surcharge for medical coverage during the plan year if you cover your spouse. Misrepresentation on this attestation constitutes fraud and may result in any or all of the following:

- Loss of medical benefit eligibility for you and your dependent(s)
- Retroactive liability for the working spouse surcharge
- Disciplinary action up to and including termination of employment

Changes in Your Spouse's Access to Healthcare Coverage: If your spouse quits or subsequently loses his or her job or eligibility for medical care, you must notify the DXC Benefits Center of this change in order to be exempt from the surcharge during the period that your covered spouse does not have access to medical coverage through another employer. Changes to spousal coverage can be made by contacting the DXC Benefits Center within 30 days of loss of eligibility.

If your covered spouse becomes eligible for medical coverage from another employer during the plan year, or you are no longer covering your spouse due to another qualified change in status event (e.g., divorce, death), it is your responsibility to inform DXC via the DXC Benefits Center of the change in eligibility in status within 30 days of the event. Failure to do so may result in any or all of the following:

- Loss of medical benefit eligibility for you and your dependent(s)
- Retroactive liability for the working spouse surcharge
- Disciplinary action up to and including termination of employment

Tobacco Use Surcharge

Consistent with DXC's promotion of wellness, an employee who enrolls in medical coverage will pay a surcharge if s/he uses tobacco. This fee is in addition to your regular medical benefit deduction and applies only to medical plans. This surcharge applies only to employees, not to spouses or dependents who use tobacco.

When you enroll in medical benefits, you will be asked to attest that you have not used tobacco for the preceding six months. If you cannot attest to your tobacco-free status, you will be charged an additional **$20 biweekly** for medical coverage during the plan year. Misrepresentation on this attestation constitutes fraud and may result in any or all of the following:

- Loss of medical benefit eligibility for you and your dependent(s)

- Retroactive liability for the tobacco surcharge
- Disciplinary action up to and including termination of employment

If you attest to being tobacco-free and subsequently begin or resume tobacco use during the plan year, it is your responsibility to notify the DXC Benefits Center within 30 days. Failure to do so may result in any or all of the following:

- Loss of medical benefit eligibility for you and your dependents
- Retroactive liability for the tobacco surcharge
- Disciplinary action up to and including termination of employment

Definition of Tobacco Use: Tobacco use is defined as having used a tobacco product within the previous six months. “Tobacco product” includes, but is not limited to: tobacco, tobacco-like, and nicotine products, such as cigarettes, cigars, pipes, electronic cigarettes, hookah pipes, snuff, and chewing tobacco (exceptions to this definition include approved smoking-cessation products, such as patches, gum, and prescriptions for smoking-cessation products prescribed by a doctor while under a doctor’s care as part of a tobacco-cessation program).

Tobacco-Cessation Programs: A DXC-sponsored tobacco-cessation program is available to all U.S. employees through the DXC LifeManagement Program administered by Magellan Health Services (See **Section 5**, **DXC LifeManagement Program**). In addition, if you enroll in a DXC-sponsored high deductible health plan, you will have access to an additional tobacco-cessation assistance through wellness vendor Virgin Pulse. You might also have access to a tobacco cessation program through your DXC-sponsored medical plan. (Please contact your medical carrier directly for information on tobacco-cessation programs that might be part of your medical plan.) You have the option to involve your personal physician if you enroll in any of the tobacco-cessation programs.

Terminating the Tobacco Use Surcharge: The tobacco use surcharge will be terminated and you will be retroactively reimbursed for surcharges incurred in the same plan year if at any time during the plan year you contact the DXC Benefits Center and truthfully attest to either of the following:

- You have not used tobacco in the previous six months; or
- You have completed a DXC-sponsored tobacco-cessation program.

The company recognizes that quitting tobacco can be a process, not an event; it may take someone several attempts before successfully quitting. If you complete a company-sponsored tobacco-cessation course during the plan year but are either unsuccessful at quitting tobacco or start using tobacco again during the same plan year, you will not have to report that you’ve failed to quit or have resumed tobacco use later in that same plan year. However, you must attest honestly as to your tobacco usage during the next Annual Benefits Open Enrollment.

Medical Examinations

No medical examination is required to obtain benefits.

Medical Claims Administrator

Your insurance carrier is the claims administrator for your medical coverage.

Identification Card

If you enroll in a DXC-sponsored medical plan, your carrier will issue you an identification (ID) card. Your ID card(s) will be mailed directly to the home address DXC has on file for you. DXC reserves the right to revoke any ID card that is misused.

Primary Care Physician (PCP) Selection

Some plans may require you to elect a primary care physician (PCP); while other plans make it optional. Please refer to your plan's insurance carrier as to whether a PCP designation is required and how to elect one.

Subrogation and Right of Recovery Provisions

Depending on your DXC medical plan, your medical insurance plan may have "subrogation" and "right of recovery" provisions.

Right of recovery means that if your medical plan pays claims arising from an injury, illness, or condition for which a covered member may have a right or claim of recovery against a responsible party, the plan may have a claim against any legal damages, awards, or settlements that the covered member recovers. The carrier's claim may give rise to a constructive trust or lien against the amount the covered member recovers.

Subrogation means that immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all rights of recovery the covered member has against any responsible party with respect to any payment made by the responsible party to the covered member due to the covered member's injury, illness, or condition to the full extent of benefits provided or to be provided by the plan.

Please review your medical plan's certificate of coverage or contact your carrier directly for more information regarding any such provisions applicable to your medical plan.

Assignment

Coverage and your rights under this Plan may **not** be assigned. A direction to pay a provider is not an assignment of any right under this Plan or of any legal or equitable right to institute any court proceeding.

Statement Of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to fewer than 48 hours following a vaginal delivery, or fewer than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that you, your physician, or other healthcare provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your medical insurance carrier directly.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

1. All stages of reconstruction of the breast on which a mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

Resources

For more information on the Newborns' and Mothers' Health Protection Act, or the Women's Health and Cancer Rights Act, visit:

- U.S. Department of Health and Human Services
  - https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/whcra
  - https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/nmhpa
- U.S. Department of Labor
  - https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/NMHPA.html
  - https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/WHCRA.html

DXC Medical Plans and Participants Eligible for Medicare or Medicaid

Benefits for Participants who are Eligible for Medicare

The plan assumes that Medicare-eligible members have enrolled in both Medicare Part A and Part B regardless of whether the member has actually enrolled. The following rules apply:

- The plan is the primary payer if you are currently working for DXC, or you first become eligible for Medicare benefits because you have end-stage renal disease (ESRD). In the case of ESRD, the plan is the primary payer for the first 30 months you are eligible for Medicare due to ESRD. At the end of the 30-month period, Medicare will be the primary payer.
- If you are age 65 or older, and the plan would otherwise be the primary payer, you may elect Medicare as the primary payer of benefits. If you do elect Medicare as the primary payer, benefits under the plan will terminate. See **Section 14, DXC Technology Company Cafeteria Program** under **Changing Your Cafeteria Plan Elections, Changing Elections/Effective Date of Enrollment Changes**.

If your **dependent** is eligible for Medicare benefits, regardless of whether s/he has actually applied for such Medicare benefits, the following rules apply:

- The plan is the primary payer if you are currently working for DXC, or your dependent first becomes eligible for Medicare benefits because s/he has end-stage renal disease (ESRD). In the case of

ESRD, the plan is the primary payer for the first 30 months your dependent is eligible for Medicare due to ESRD. At the end of the 30- month period, Medicare is the primary payer.

- If your dependent is age 65 or older, and the plan would otherwise be the primary payer, s/he may elect Medicare as the primary payer of benefits. If s/he does elect Medicare as the primary payer, benefits under the plan will terminate. See **Section 14, DXC Technology Company Cafeteria Program** under **Changing Your Cafeteria Plan Elections, Changing Elections/Effective Date of Enrollment Changes**.

Medicare is primary to any COBRA coverage. See **Coordinating COBRA with Other Coverage**, below, under **Section 6, COBRA Rights**.

Important Notice to Medicare Eligible Participants from DXC Technology Company Regarding Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with DXC Technology Company and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you consider joining, you should compare your current coverage, including which drugs are covered and at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The DXC Employee Benefits Fiduciary Committee, as Plan Administrator, has determined that the prescription drug coverage offered by the medical plans that are part of the DXC Fully Insured Employee Welfare Benefits Plan are, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered "creditable coverage."

Because your existing coverage is creditable coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare prescription drug plan when you first become eligible for Medicare and each year during the Medicare-designated period. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

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

This Section 2 provides an overview of the prescription drug benefits available through the DXC medical plans. You can review additional details of prescription drug benefits via the DXC Benefits Center or by calling your medical plan provider directly. Provider contact information is provided in the back of this Guidebook.

If you decide to join a Medicare drug plan and drop your DXC prescription drug coverage, be aware that you and your dependents will be able to get this coverage back if the plan(s) are still available and you meet the eligibility requirements for health coverage.

Please call the DXC Benefits Center (1.888.305.5499) for more information about what happens to your coverage if you join a Medicare prescription plan.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

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

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

More Information About This Notice or Your Current Prescription Drug Coverage

Call the DXC Benefits Center (1.888.305.5499). **NOTE:** Each year you will receive a Medicare notice with the information provided above. You will also receive it before the next period that you can join a Medicare drug plan and if this coverage through DXC changes. You also may request a copy of this notice at any time.

More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the Medicare and You handbook for the telephone number) for personalized help
- Call 1.800.MEDICARE (1.800.633.4227). TTY users, call 1.877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security Administration (SSA) at www.socialsecurity.gov, or call SSA at 1.800.772.1213 (TTY 1.800.325.0778).

Remember: The information provided above serves as a creditable coverage notice and you should keep a copy for your records. If you join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join as part of the requirements to show whether you have maintained creditable coverage and, therefore, whether or not you are

Date: January 1, 2024

Name of Entity/Sender:	DXC Technology Company c/o DXC Employee Benefits Fiduciary Committee (Plan Administrator)
Contact--Position/Office:	DXC Benefits Center (managed by Businessolver)
Address:	10 North Park Drive Suite 400 Hunt Valley, MD 21030
Phone Number:	1.888.305.5499

If You Have Medicaid Coverage

If you or your dependents are covered under a state's Medicaid program, the DXC plan will be primary and will pay benefits before Medicaid. The DXC plan shall not reduce or deny benefits for you or your covered dependents to reflect eligibility to receive medical assistance under a state Medicaid program. In addition, the plan shall reimburse any state Medicaid program for the cost of items and services provided under the state program that should have been paid for by the DXC plan, and will honor any subrogation rights that a state has to recoup such mistaken payments. Medicaid is a state plan for medical assistance approved under Title XIX of the Social Security Act of 1965, as amended.

Your DXC medical carrier can release or obtain data as necessary to administer this provision. Your carrier can also make or recover payments.

When this provision operates to reduce the total amount of benefits otherwise payable as total benefits allowable to a person covered under this plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this plan.

Benefits Provided

Introduction

Employees who reside within the United States (except those in the state of Hawaii, or a U.S. Territory) should referto the provision in **Section 2** titled **Standard U.S. Medical Benefits**.

Employees who reside in the state of Hawaii should refer to the provision in **Section 2** titled **Medical Benefits for Employees Residing in Hawaii**.

Employees who reside in Puerto Rico should refer to the provision in **Section 2** titled **Medical Benefits for Employees Residing in Puerto Rico**.

Employees who reside in the U.S. Virgin Islands should refer to the provision in **Section 2** titled **Medical Benefits for Employees on Expatriate Assignment** as the same benefits apply to you.

Employees who are assigned to work outside the U.S. for 180 days or more during a consecutive 12-month period should refer to the provision in **Section 2** titled **Medical Benefits for Employees on Expatriate Assignment.**

Standard U.S. Medical Benefits

Introduction

Standard U.S. medical benefits are offered through the Aon Active Health Exchange™ (Aon Exchange), which allows employees to select both the plan design as well as the insurance carrier for the plan design they elect. Employees who are eligible for Standard U.S. Medical Benefits may choose from the following plan designs on the Aon Exchange:

- Bronze
- Bronze Plus
- Silver
- Gold I
- Gold II (California only)
- Platinum

A summary of these plans is provided below. In the event of a conflict between the benefits described here, and benefits described in the applicable carrier's Certificate of Coverage, the Certificate of Coverage shall control. Employees who reside in California should also see the section **Exchange Features Unique to California**, below.

Participating Carriers

The following carriers are participating in the Aon Exchange during the 2024 plan year:

- Aetna
- Anthem BlueShield
- Cigna
- Dean/Previa 360
- Geisinger
- Priority Health
- Health Net
- Kaiser Permanente
- Medical Mutual of Ohio
- UnitedHealthcare
- UPMC Health Plan

Your home zip code of record will determine which carriers you may select, as not all carriers are available in all parts of the U.S.

Types of Networks

Carriers available on the Aon Exchange may utilize one of the following types of networks:

Preferred Provider Network (PPO): offers both in- and out-of-network benefits; generally, does not require a referral from your primary care physician to see a specialist

Point of Service (POS): offers both in- and out-of-network benefits; generally, requires a referral from your primary care physician to see a specialist

Exclusive Provider Organization (EPO): offers in-network benefits only; generally, does not require a referral from your primary care physician to see a specialist

Health Maintenance Organization (HMO): offers in-network benefits only; generally, requires a referral from your primary care physician to see a specialist

Please check directly with your carrier regarding referral requirements for seeing a specialist.

Additional Eligibility Requirements

In addition to meeting the general eligibility requirements outlined starting on page 2-1, you must reside within the United States to be eligible for Standard U.S. Medical Benefits.

Note however, that residents of Hawaii are not eligible for these plans and should see the section below **Medical Benefits for Employees Residing in Hawaii**.

Covering Dependents

The following coverage tiers are available for the Aon Exchange medical plans:

- Employee only
- Employee + Spouse
- Employee + Child(ren)
- Family (Employee and Spouse and Child[ren])

Wellness Program

The Bronze, Bronze Plus, and Silver plans are high deductible health plans; therefore, if you enroll in one of these plans, you will be eligible to participate in the DXC Healthy Behaviors Wellness Program administered by Virgin Pulse. See details later in this section.

Benefits Provided

A high-level summary of the benefits is provided in the table on the following pages. Each “metallic” plan is generallythe same across all carriers; however, there may be some differences in how each carrier administers the plan (e.g.,prescription drug formularies and provider networks may be different). Contact your carrier directly for more detailed information and/or questions related to a specific medical condition or treatment. Further detail is available on the DXC Benefits Center portal at mydxcbenefitscenter.com.

Standard U.S. Medical Plans: Summary of In-Network Benefits

Service	Bronze	Bronze Plus	Silver	Gold I	Platinum
Plan Type[1]	HDHP[2] (PPO/POS Network)	HDHP[2] (PPO/POS Network)	HDHP[2] (PPO/POS Network)	PPO/POS	PPO/POS or HMO/EPO[3]
Deductible (individual/with dependents)	$3,300/$6,600 (embedded)	$2,450/$4,900	$1,500/$3,000	$800/$1,600 (embedded)	$250/$500 (embedded)
Coinsurance (amount covered)	75% after deductible	75% after deductible	75% after deductible	75% after deductible	85% after deductible
Office Visit – Primary Physician	75% after deductible	75% after deductible	75% after deductible	$25 member copay	$25 member copay
Office Visit – Specialist	75% after deductible	75% after deductible	75% after deductible	$40 member copay	$40 member copay
Preventive Care	100% (no deductible)	100% (no deductible)	100% (no deductible)	100% (no deductible)	100% (no deductible)
Emergency Room[4]	75% after deductible	75% after deductible	75% after deductible	75% after deductible	85% after deductible
In-Patient Hospital	75% after deductible	75% after deductible	75% after deductible	75% after deductible	85% after deductible
Annual Out-of-pocket maximum In-Network (Individual/with Dependents)	$6,400/$12,800 (embedded)	$3,900/$7,8000	$3,800/$7,6000	$3,600/$7,200 (embedded)	$2,300/$4,600 (embedded)
Prescription Drugs – Retail (30-day supply)					
Tier 1	75% after deductible	75% after deductible	75% after deductible	$10 member copay	$8 member copay
Tier 2	75% after deductible	75% after deductible	75% after deductible	$40 member copay	$30 member copay
Tier 3	75% after deductible	75% after deductible	75% after deductible	$60 member copay	$50 member copay
Prescription Drugs – Mail Order (90-day supply)					
Tier 1	75% after deductible	75% after deductible	75% after deductible	$25 member copay	$20 member copay
Tier 2	75% after deductible	75% after deductible	75% after deductible	$100 member copay	$75 member copay
Tier 3	75% after deductible	75% after deductible	75% after deductible	$150 member copay	$125 member copay

1. A PPO (Preferred Provider Organization) or POS (Point of Service) plan offers both in- and out-of-network coverage; however, you may need to a referral to see a specialist. An HMO (Health Maintenance Organization) or EPO (Exclusive Provider Network) offers in-network coverage only, and usually requires a referral to see a specialist. Check with your carrier for specific network type and requirements.
2. High Deductible Health Plan: eligible to participate in a Health Savings Account if participant meets IRS criteria.
3. If Kaiser is selected as the carrier, the Platinum plan is administered as an HMO with in-network benefits only.
4. Depending on your carrier, non-emergency use of emergency room benefits might not be covered; please check directly with your carrier.

Standard U.S. Medical Plans: Summary of Out-of-Network Benefits

Service	Bronze[1]	Bronze Plus[1]	Silver[1]	Gold I[1]	Platinum[1]
Plan Type[2]	HDHP[3] (PPO/POS Network)	HDHP[3] (PPO/POS Network)	HDHP[3] (PPO/POS Network)	PPO/POS	PPO/POS[4] (out-of-network benefits notavailable if an HMO/EPO)
Deductible (individual/with dependents)	$3,300/$6,600 (embedded)	$2,450/$4,900	$1,500/$3,000	$1,600/$3,200 (embedded)	$5,000/$10,000 (embedded)
Coinsurance (amount covered)	55% after deductible	55% after deductible	55% after deductible	55% after deductible	65% after deductible
Office Visit – Primary Physician	55% after deductible	55% after deductible	55% after deductible	55% after deductible	65% after deductible
Office Visit – Specialist	55% after deductible	55% after deductible	55% after deductible	55% after deductible	65% after deductible
Preventive Care	55% after deductible	55% after deductible	55% after deductible	55% after deductible	65% after deductible
Emergency Room[5]	75% after deductible	75% after deductible	75% after deductible	75% after deductible	85% after deductible
In-Patient Hospital	55% after deductible	55% after deductible	55% after deductible	55% after deductible	65% after deductible
Annual Out-of-pocket maximum Out-of-Network (Individual/with Dependents)	$12,800/$25,600 (embedded)	$11,500/$23,000	$8,000/$16,000	$7,200/$14,400 (embedded)	$11,500/$23,000 (embedded)
Prescription Drugs – Retail (30-day supply)					
Tier 1	55% after deductible	55% after deductible	55% after deductible	50% with limitations	50% with limitations
Tier 2	55% after deductible	55% after deductible	55% after deductible	50% with limitations	50% with limitations
Tier 3	55% after deductible	55% after deductible	55% after deductible	50% with limitations	50% with limitations
Prescription Drugs – Mail Order (90-day supply)	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable

1. May be subject to usual and customary charge limits or other limitations.
2. A PPO (Preferred Provider Organization) or POS (Point of Service) plan offers both in- and out-of-network coverage; however, you may need to a referral to see a specialist. An HMO(Health Maintenance Organization) or EPO (Exclusive Provider Network) offers in-network coverage only, and usually requires a referral to see a specialist. Check with your carrier for specific network type and requirements.
3. High Deductible Health Plan: eligible to participate in a Health Savings Account if participant meets IRS criteria.
4. If Kaiser is selected as the carrier, the Platinum plan is administered as an HMO with in-network benefits only.
5. Depending on your carrier, non-emergency use of emergency might not be covered; please check directly with your carrier.

Exchange Features Unique to California

There are some additional features to the Aon Exchange that are unique to California:

- Some carriers administer the plans as HMOs or EPOs with in-network benefits only
- The Bronze Plus, Silver and Gold plan designs differ slightly based on the carrier you elect

PPO/POS vs. HMO/EPO Option

In the state of California, insurance carriers are given the option of administering each plan as either a PPO or POS — with both in- and out-of-network benefits — or as an HMO or EPO with in-network benefits only. Check with your carrier to confirm whether there are any referral requirements. The participating carriers in California have elected to administer the plans as follows:

Carrier	Bronze	Bronze Plus	Silver	Gold	Platinum
Aetna	PPO/POS	PPO/POS	PPO/POS	PPO/POS	PPO/POS
Anthem BCBS	**HMO/EPO**	**HMO/EPO**	**HMO/EPO**	**HMO/EPO**	**HMO/EPO**
Cigna	PPO/POS	PPO/POS	PPO/POS	**HMO/EPO**	**HMO/EPO**
Health Net – Northern CA	**HMO/EPO**	**HMO/EPO**	**HMO/EPO**	**HMO/EPO**	**HMO/EPO**
Health Net – Southern CA	PPO/POS	PPO/POS	PPO/POS	**HMO/EPO**	**HMO/EPO**
Kaiser	**HMO/EPO**	**HMO/EPO**	**HMO/EPO**	**HMO/EPO**	**HMO/EPO**
United Healthcare	PPO/POS	PPO/POS	PPO/POS	PPO/POS	PPO/POS

Plan Design Differences

In addition to differences in how the carriers are administering the plans, there are several plan design differences in California.

Gold II Plan: Insurance carriers in the state of California are also given the option of offering an alternative Gold Plan, called Gold II. Carriers administering the Gold Plan as an HMO or EPO in California (Cigna, Health Net, Kaiser) are offering Gold II instead of Gold I. **There is no coverage for out-of-network services in the Gold II Plan.**

Bronze Plus and Silver Plans: Due to recent legislative changes in California, the Bronze Plus and Silver plans offered by California-based carriers have different deductibles and out-of-pocket maximums for employees covering dependents. Those carriers are:

- Kaiser (plans are HMO/EPOs per table above)
- Health Net – Northern California (plans are HMO/EPOs per table above)
- Health Net – Southern California (plans are PPO/POS per table above)

In the affected plans, the deductible for Employee + Spouse, Employee + Child(ren), and Family coverage tiers will be an “embedded” deductible. This means that once a particular family member has met the embedded deductible, that person will start to receive benefits while the other family members must wait until the entire family deductible is satisfied. The annual out-of-pocket maximum (MOOP) works in a similar manner. Examples are provided following the benefits summaries, under **Operation of Deductibles and Maximum Out-of-Pocket Limits**.

2. Medical Plans

A high-level summary of the California benefits is provided in the following table. In addition to the plan design differences referenced above, there may be some differences in how each carrier administers the plan (e.g., prescription drug formularies and provider networks may be different). Contact your carrier directly for more detailed information and/or questions related to a specific medical condition or treatment. Further detail is available on the DXC Benefits Center portal at myDXCbenefitscenter.com.

California Medical Plans: Summary of In-Network Benefits

Service	Bronze	Bronze Plus	Silver	Gold I	Gold II	Platinum
Plan Type[1]	HDHP[2,3] (PPO/POS network)			PPO/POS or HMO/EPO[4, 5]	HMO/EPO[6]	PPO/POS or HMO/EPO[7]
Deductible (individual/with dependents)	$3,300/$6,600 (embedded)			$800/$1,600 (embedded)	None	$250/$500
Coinsurance (amount covered)	75% after deductible			75% after deductible	70%	85%
Office Visit – Primary Physician	75% after deductible			$25 member copay	$25 member copay	$25 member copay
Office Visit – Specialist	75% after deductible			$40 member copay	$40 member copay	$40 member copay
Preventive Care	100% (no deductible)			100% (no deductible)	100% (no deductible)	100% (no deductible)
Emergency Room[8]	75% after deductible			75% after deductible	70% covered	85% after deductible
In-Patient Hospital	75% after deductible	See Following Pages	See Following Pages	75% after deductible	70% covered	85% after deductible
Annual Out-of-pocket maximum In-Network (Individual/with Dependents)	$6,450/$12,800 (embedded)			$3,600/$7,200 (embedded)	$5,400/$10,800	$2,300/$4,600 (embedded)
Prescription Drugs – Retail (30-day supply)						
Tier 1	75% after deductible			$10 member copay	$10 member copay	$8 member copay
Tier 2	75% after deductible			$40 member copay	$40 member copay	$30 member copay
Tier 3	75% after deductible			$60 member copay	$60 member copay	$50 member copay
Prescription Drugs – Mail Order (90-day supply)						
Tier 1	80% after deductible			$25 member copay	$25 member copay	$20 member copay

Service	Bronze	Bronze Plus	Silver	Gold I	Gold II	Platinum
Tier 2	80% after deductible			$100 member copay	$100 member copay	$75 member copay
Tier 3	80% after deductible			$150 member copay	$150 member copay	$125 member copay

1. A PPO (Preferred Provider Organization) or POS (Point of Service) plan offers both in- and out-of-network coverage; however, you may need to a referral to see a specialist. An HMO (Health Maintenance Organization) or Exclusive Provider Organization (EPO) offers in-network coverage only, and usually requires a referral to see a specialist. Check with your carrier for specific requirements.
2. High Deductible Health Plan: eligible to participate in a Health Savings Account if participant meets IRS criteria
3. If Anthem, Health Net of Northern California, or Kaiser is elected as the carrier, the Bronze Plan is administered as an HMO/EPO with in-network benefits only
4. Offered only by: Aetna, Anthem BCBS, UnitedHealthcare
5. If Anthem is elected as the carrier the Gold Plan is administered as an HMO/EPO with in-network benefits only
6. Offered only by: Cigna, Health Net (Northern and Southern California), and Kaiser
7. If Anthem, Cigna, Health Net (Northern and Southern California), or Kaiser is selected as the carrier, the Platinum plan is administered as an HMO/EPO with in-network benefits only
8. Depending on your carrier, non-emergency use of emergency room benefits might not be covered; please check directly with your carrier

Bronze-Plus Plan – California (In-Network)

Carrier	Aetna, Anthem BCBS, Cigna, UnitedHealthcare	Kaiser, Health Net	Kaiser	Health Net
Coverage Tiers	**All**	**Employee Only**	**With Dependents**	**With Dependents**
Plan Type[1]	HDHP[2, 3] (PPO/POS or HMO/EPO network)	HMO/EPO HDHP or PPO/POS HDHP[2, 4]	HMO/EPO HDHP[2,]	HMO/EPO HDHP or PPO/POS HDHP[2, 5]
Deductible	$2,450/$4,900 (individual/with dependents)	$2,450	$4,900 ($2,800 embedded)	$4,900 ($2,800 embedded)
Coinsurance (amount covered)	75% after deductible	75% after deductible	75% after deductible	75% after deductible
Office Visit – Primary Physician	75% after deductible	75% after deductible	75% after deductible	75% after deductible
Office Visit – Specialist	75% after deductible	75% after deductible	75% after deductible	75% after deductible
Preventive Care	100% (no deductible)	100% (no deductible)	100% (no deductible)	100% (no deductible)
Emergency Room[6]	75% after deductible	75% after deductible	75% after deductible	75% after deductible
In-Patient Hospital	75% after deductible	75% after deductible	75% after deductible	75% after deductible
Annual Out-of-pocket maximum In-Network	$3,900/$7,800	$3,900	$7,800 ($3,900 embedded)	$7,800 ($3,900 embedded)
Prescription Drugs – Retail (30-day supply)				
Tier 1	75% after deductible	75% after deductible	75% after deductible	75% after deductible
Tier 2	75% after deductible	75% after deductible	75% after deductible	75% after deductible
Tier 3	75% after deductible	75% after deductible	75% after deductible	75% after deductible
Prescription Drugs – Mail Order (90-day supply)				
Tier 1	75% after deductible	75% after deductible	75% after deductible	75% after deductible
Tier 2	75% after deductible	75% after deductible	75% after deductible	75% after deductible
Tier 3	75% after deductible	75% after deductible	75% after deductible	75% after deductible

1. A PPO (Preferred Provider Organization) or POS (Point of Service) plan offers both in- and out-of-network coverage; however, you may need to a referral to see a specialist. An HMO (Health Maintenance Organization) or Exclusive Provider Organization (EPO) offers in-network coverage only, and usually requires a referral to see a specialist. Check with your carrier for specific requirements.
2. High Deductible Health Plan: eligible to participate in a Health Savings Account if participant meets IRS criteria
3. HMO/EPO if offered by Anthem; PPO/POS if offered by Aetna, Cigna, or United Healthcare
4. HMO/EPO if offered by Kaiser or Health Net of Northern California; PPO/POS if offered by Health Net of Southern California
5. HMO/EPO if offered by Health Net of Northern California; PPO/POS if offered by Health Net of Southern California
6. Depending on your carrier, non-emergency use of emergency room benefits might not be covered; please check directly with your carrier

Silver Plan – California (In-Network)

Carriers	Aetna, Anthem BCBS, Cigna, UnitedHealthcare	Kaiser, Health Net	Kaiser	Health Net
Coverage Tiers	**All**	**Employee Only**	**With Dependents**	**With Dependents**
Plan Type[1]	HDHP[2, 3] (PPO/POS network)	HMO/EPO HDHP or PPO/POS HDHP[2, 4]	HMO/EPO HDHP[2]	HMO/EPO HDHP or PPO/POS HDHP[2, 5]
Deductible	$1,500/$3,000 (individual/with dependents)	$1,500	$3,000 ($2,800 embedded)	$3,500 ($2,800 embedded)
Coinsurance (amount covered)	75% after deductible	75% after deductible	75% after deductible	75% after deductible
Office Visit – Primary Physician	75% after deductible	75% after deductible	75% after deductible	75% after deductible
Office Visit – Specialist	75% after deductible	75% after deductible	75% after deductible	75% after deductible
Preventive Care	100% (no deductible)	100% (no deductible)	100% (no deductible)	100% (no deductible)
Emergency Room[6]	75% after deductible	75% after deductible	75% after deductible	75% after deductible
In-Patient Hospital	75% after deductible	75% after deductible	75% after deductible	75% after deductible
Annual Out-of-pocket maximum In-Network	$3,800/$7,600	$3,800	$7,600 ($3,800 embedded)	$7,600 ($3,800 embedded)
Prescription Drugs – Retail (30-day supply)				
Tier 1	75% after deductible	75% after deductible	75% after deductible	75% after deductible
Tier 2	75% after deductible	75% after deductible	75% after deductible	75% after deductible
Tier 3	75% after deductible	75% after deductible	75% after deductible	75% after deductible
Prescription Drugs – Mail Order (90-day supply)				
Tier 1	75% after deductible	75% after deductible	75% after deductible	75% after deductible
Tier 2	75% after deductible	75% after deductible	75% after deductible	75% after deductible
Tier 3	75% after deductible	75% after deductible	75% after deductible	75% after deductible

1. A PPO (Preferred Provider Organization) or POS (Point of Service) plan offers both in- and out-of-network coverage; however, you may need to a referral to see a specialist. An HMO (Health Maintenance Organization) or Exclusive Provider Organization (EPO) offers in-network coverage only, and usually requires a referral to see a specialist. Check with your carrier for specific requirements.

2. High Deductible Health Plan: eligible to participate in a Health Savings Account if participant meets IRS criteria
3. HMO/EPO if offered by Anthem; PPO/POS if offered by Aetna, Cigna, or United Healthcare
4. HMO/EPO if offered by Kaiser or Health Net of Northern California; PPO/POS if offered by Health Net of Southern California
5. HMO/EPO if offered by Health Net of Northern California; PPO/POS if offered by Health Net of Southern California
6. Depending on your carrier, non-emergency use of emergency room benefits might not be covered; please check directly with your carrier

California Medical Plans: Summary of Out-of-Network Benefits

Service	Bronze[1]	Bronze Plus[1]	Silver[1]	Gold I[1]	Gold II[1]	Platinum[1]
Plan Type[2]	HDHP[3,4] PPO/POS network (out-of-network benefits not available if an HMO/EPO)			PPO/POS[5, 6] (out-of-network benefits not available if an HMO/EPO)	HMO/EPO[7]	PPO/POS[8] (out-of-network benefits not available if an HMO/EPO)
Deductible (individual/with dependents)	$3,300/$6,600 (embedded)			$1,600/$3,200 (embedded)		$5,000/$10,000 (embedded)
Coinsurance (amount covered)	55% after deductible			55% after deductible		65% after deductible
Office Visit – Primary Physician	55% after deductible			55% after deductible		65% after deductible
Office Visit – Specialist	55% after deductible	See Following Pages	See Following Pages	55% after deductible		65% after deductible
Preventive Care	55% after deductible			55% after deductible		65% after deductible
Emergency Room[9]	75% after deductible			75% after deductible		85% after deductible
In-Patient Hospital	55% after deductible			55% after deductible		65% after deductible
Annual Out-of-pocket maximum In-Network (Individual/with Dependents)	$12,800/$25,600 (embedded)			$7,200/$14,400 (embedded)	Not applicable	$11,500/$23,000 (embedded)
Prescription Drugs – Retail (30-day supply)						
Tier 1	55% after deductible			50% with limitations		50% with limitations
Tier 2	55% after deductible			50% with limitations		50% with limitations
Tier 3	55% after deductible			50% with limitations		50% with limitations
Prescription Drugs – Mail Order(90-day supply)	Not applicable			Not applicable		Not applicable

1. May be subject to usual and customary charge limits or other limitations

2. A PPO (Preferred Provider Organization) or POS (Point of Service) plan offers both in- and out-of-network coverage; however, you may need to a referral to see a specialist. An HMO (Health Maintenance Organization) or Exclusive Provider Organization (EPO) offers in-network coverage only, and usually requires a referral to see a specialist. Check with your carrier for specific requirements.
3. High Deductible Health Plan: eligible to participate in a Health Savings Account if participant meets IRS criteria
4. If Anthem, Health Net of Northern California, or Kaiser is elected as the carrier, the Bronze Plan is administered as an HMO/EPO with in-network benefits only
5. Offered only by: Aetna, Anthem BCBS, UnitedHealthcare
6. If Anthem is elected as the carrier, the Gold plan is administered as an HMO/EPO with in-network benefits only
7. Offered only by: Cigna, Health Net (Northern and Southern California), and Kaiser
8. If Anthem, Cigna, Health Net (Northern and Southern California), or Kaiser is selected as the carrier, the Platinum plan is administered as an HMO/EPO with in-network benefits only
9. Depending on your carrier, non-emergency use of emergency room benefits might not be covered; please check directly with your carrier

California: Bronze-Plus Plan – Summary of Out-of-Network Benefits

Carrier	Aetna, Cigna, UnitedHealthcare[1]	Health Net SoCal[1]		Anthem BCBS, Health Net NorCal, Kaiser
Coverage Tiers	**All Coverage Tiers**	**Employee Only**	**With Dependents**	**All Coverage Tiers**
Plan Type[2]	HDHP[3] (PPO/POS network)	HDHP[3] (PPO/POS network)	HDHP[3] (PPO/POS network)	HMO/EPO HDHP[3]
Deductible	$2,450/$4,900	$2,450	$4,900 ($2,800 embedded)	Out of network benefits not available
Coinsurance (amount covered)	55% after deductible	55% after deductible	55% after deductible	
Office Visit – Primary Physician	55% after deductible	55% after deductible	55% after deductible	
Office Visit – Specialist	55% after deductible	55% after deductible	55% after deductible	
Preventive Care	55% after deductible	55% after deductible	55% after deductible	
Emergency Room[4]	7580% after deductible	75% after deductible	75% after deductible	
In-Patient Hospital	55% after deductible	55% after deductible	55% after deductible	
Annual Out-of-pocket maximum In-Network	$11,500/$23,000	$11,500	$23,000 ($11,500 embedded)	
Prescription Drugs – Retail (30-day supply)				
Tier 1	55% after deductible	55% after deductible	55% after deductible	
Tier 2	55% after deductible	55% after deductible	55% after deductible	
Tier 3	55% after deductible	55% after deductible	55% after deductible	
Prescription Drugs – Mail Order (90-day supply)	Not applicable	Not applicable	Not applicable	

1. May be subject to usual and customary charge limits or other limitations when using providers outside of network
2. A PPO (Preferred Provider Organization) or POS (Point of Service) plan offers both in- and out-of-network coverage; however, you may need to a referral to see a specialist. An HMO (Health Maintenance Organization) or Exclusive Provider Organization (EPO) offers in-network coverage only, and usually requires a referral to see a specialist. Check with your carrier for specific requirements.
3. High Deductible Health Plan: eligible to participate in a Health Savings Account if participant meets IRS criteria
4. Depending on your carrier, non-emergency use of emergency room benefits might not be covered; please check directly with your carrier

California: Silver Plan – Summary of Out-of-Network Benefits

Carrier	Aetna, Cigna, UnitedHealthcare[1]	Health Net SoCal[1]		Anthem BCBS, Health Net NorCal, Kaiser
Coverage Tiers	**All Coverage Tiers**	**Employee Only**	**With Dependents**	**All Coverage Tiers**
Plan Type[2]	HDHP[3] (PPO/POS network)	HDHP[3] (PPO/POS network)	HDHP[3] (PPO/POS network)	HMO/EPO HDHP[3]
Deductible	$1,500/$3,000	$1,500	$3,500 ($2,800 embedded)	Out-of-network benefits notavailable
Coinsurance (amount covered)	55% after deductible	55% after deductible	55% after deductible	
Office Visit – Primary Physician	55% after deductible	55% after deductible	55% after deductible	
Office Visit – Specialist	55% after deductible	55% after deductible	55% after deductible	
Preventive Care	55% after deductible	55% after deductible	55% after deductible	
Emergency Room[4]	75% after deductible	75% after deductible	75% after deductible	
In-Patient Hospital	55% after deductible	55% after deductible	55% after deductible	
Annual Out-of-pocket maximum In-Network	$8,000/$16,000	$8,000	$16,000 ($7,600 embedded)	
Prescription Drugs – Retail (30-day supply)				
Tier 1	55% after deductible	55% after deductible	55% after deductible	
Tier 2	55% after deductible	55% after deductible	55% after deductible	
Tier 3	55% after deductible	55% after deductible	55% after deductible	
Prescription Drugs – Mail Order (90-day supply)	Not applicable	Not applicable	Not applicable	

1. May be subject to usual and customary charge limits or other limitations when using providers outside of network
2. A PPO (Preferred Provider Organization) or POS (Point of Service) plan offers both in- and out-of-network coverage; however, you may need to a referral to see a specialist. An HMO (Health Maintenance Organization) or Exclusive Provider Organization (EPO) offers in-network coverage only, and usually requires a referral to see a specialist. Check with your carrier for specific requirements.
3. High Deductible Health Plan: eligible to participate in a Health Savings Account if participant meets IRS criteria
4. Depending on your carrier, non-emergency use of emergency room benefits might not be covered; please check directly with your carrier

Operation of Deductibles and Maximum Out-of-Pocket Limits

Medical plans offered through the Aon Active Health Exchange™ may utilize either a "true family" or an "embedded" annual deductible and maximum out-of-pocket limit (MOOP) for coverage tiers that cover dependents. All of the examples and illustrations below are based on in-network deductibles and expenses. Out-of-network deductibles may be different, and will accrue and apply separately from those in-network. Although MOOPs are not illustrated, they accrue and apply in a similar manner to deductibles.

True Family Deductible

Under this approach, **the entire family deductible must be met before any benefits are paid by the plan.** The family deductible can be met by one covered individual, or by all covered individuals combined, as illustrated in the example below.

Example: If you reside outside of California, and elect the Silver plan, the total in-network deductible is $1,500 for employee-only coverage, and $3,000 if you are covering dependents. (Note: In California, the type of deductible applicable to the Bronze Plus and Silver plans depends on the carrier you choose. See **Embedded Deductible and the Bronze Plus and Silver Plans in California**, below.) This plan has a true family deductible; therefore, if you are covering dependents, the entire family deductible must be met before any benefits are paid by the plan. The family deductible can be met by one covered individual, or by all covered individuals combined, as shown in Illustration A, below:

Illustration A: Five-Member Family Silver Plan	**Deductible Credited During Calendar Year**
	In-Network
Member No. 1	$2,000
Member No. 2	$200
Member No. 3	$300
Member No. 4	$400
Member No. 5	$100
Annual Family Deductible	$3,000

In Illustration A, the plan will not pay benefits for any member until the entire $3,000 deductible has been met. In this case it has been met.

Embedded Deductible

Under this approach, if you are covering dependents, the plan will start paying benefits for a covered individual once that individual has met a separate deductible -- usually equal to the deductible applicable under the employee-only coverage tier. In addition, there's a cap on how much of each covered individual's incurred expenses will be credited towards the overall deductible.

Example: Under the Gold plan, the total in-network deductible is $800 for employee-only coverage, and $1,600 if you are covering dependents. This plan has an embedded deductible, which means that if you are covering dependents, once any individual incurs $800 of in-network expenses, the plan will start to pay benefits for that member, even if the $1,600 family deductible has not been met. However, no more than $800 of any individual's expenses will count towards the $1,600 family deductible. This is shown in Illustrations B and C, below:

Illustration B: Three Member Family Gold Plan	Deductible Credited During Calendar Year	
	In-Network	
	Incurred Expenses	Credited Towards Deductible
Member No. 1	$1,100	$800
Member No. 2	$600	$600
Member No. 3	$100	$100
Total	**$1,800**	**$1,500**

In Illustration B, the family has incurred $1,800 of in-network expenses, but the **$1,600 family deductible** has not been met:

- Member No. 1 has incurred $1,100 of expenses; therefore, he has met the embedded deductible of $800, and the plan begins to pay benefits for him. However, only $800 of his expenses are credited toward the family deductible.
- Member's 2 and 3 won't receive benefits until they incur another $100 of expenses between them, at which point the $1,600 family deductible will have been met.

Illustration C Three Member Family Gold Plan	Deductible Credited During Calendar Year	
	In-Network	
	Incurred Expenses	Credited Towards Deductible
Member No. 1	$1,100	$800
Member No. 2	$600	$600
Member No. 3	$200	$200
Total	**$1,900**	**$1,600**

In Illustration C, the family has now incurred $1,900 of in-network expenses and the **$1,600 family deductible** has been met:

- Member No. 1 incurred $1,100 of expenses; therefore, he met the embedded deductible of $800, and the plan began to pay benefits for him. However, only $800 of his expenses were credited toward the family deductible.
- At this point, although Members 2 and 3 have not met the embedded $800 individual deductible, they have incurred $800 of expenses between them, which when combined with Member 1, meets the family deductible of $1,600. The plan will now pay in-network benefits for all covered members.

Embedded Deductible and the Bronze Plus and Silver Plans in California

If you reside in California, cover dependents, elect the Bronze Plus or Silver plan, and elect either Kaiser or Health Net as your carrier, the deductible will function as an embedded rather than family deductible. Moreover, although an embedded deductible is generally equal to the deductible under the employee-only coverage tier, ***this is not the case with these particular plans***.

Example: If you reside in California and elect the Silver plan with Kaiser as your carrier, the deductible is $1,500 for employee only, and $3,000 if you are covering dependents but with an embedded deductible of $2,800. This is shown in Illustration D, below:

Illustration D: Three Member Family Kaiser Silver Plan (CA)	Deductible Credited During Calendar Year	
	In-Network	
	Incurred Expenses	Credited Towards Deductible
Member No. 1	$2,000	$2,000
Member No. 2	$100	$100
Member No. 3	$200	$200
Total	**$2,300**	**$2,300**

In Illustration D, the family has incurred $2,300 of in-network expenses:

- The $3,000 family deductible has not been met.
- Member No. 1 incurred $2,000 of expenses. Although this is greater than the $1,500 deductible under the employee-only coverage tier, it does not meet the $2,800 embedded deductible for this particular plan.
- At this point, Members 2 and 3 have not met the embedded $2,800 individual deductible; however, if Members 2 and 3 incur an additional $700 of expenses between them, the entire $3,000 family deductible will have been met, and the plan will begin paying in-network benefits for all covered members.

Cost of Participation in the Plan

There are two components to the cost of participation in medical plans offered through the Aon Exchange: the total insurance premium and the company credit or subsidy.

Insurance Premiums and Geographic Pricing Regions: All Aon Exchange plans are fully insured by the carriers. The carriers underwrite and price their plans based on 22 different geographic pricing regions, which reflect differences in risk and cost of care from one part of the country to another. The 2024 geographic pricing regions are:

1.	Pacific NW (AK, ID, MT, WY)
2.	Southwest (NV, UT)
3.	Michigan & Ohio (MI, OH)
4.	Plains (CO, KS, MO, NE)
5.	Midwest (IA, MN, ND, SD)
6.	Heartland (IN, KY, WI, WV)
7.	South Central (AR, LA)
8.	South (AL, GA, MS, TN)
9.	Florida
10.	Mid-Atlantic (DC, MD, DE, SC, VA)
11.	New England (CT, MA, ME, NH, RI, VT)
12.	NJ & Greater Philadelphia
13.	Texas
14.	Northern California
15.	Southern California
16.	New York
17.	Oregon &Washington
18.	Arizona
19.	New Mexico & Oklahoma
20.	Illinois
21.	North Carolina
22.	Southern & Western Pennsylvania

This means that the price you pay for a medical plan will vary based on where you live, even if you elect the same plan design, coverage tier, and carrier as a colleague living in a different part of the country. You will be able to see the premiums for plans in your area when you log on to myDXCbenefitscenter.com.

Company Credit: DXC will provide you with a credit with which you can purchase DXC medical benefits. (Note: This credit can only be used for the purchase of DXC medical benefits.) The amount of credit you receive will be based on the following factors:

- Geographic pricing region in which you reside
- Your current salary band

Coverage tier (e.g., Employee, Family) The 2024 salary bands are:

Band	Range
1	<$70,0000
2	$70,000 - $89,999.99
3	>$90,000

You will be able to see your medical credit amount when you log into the enrollment portal. If your geographic location, salary, or coverage tier changes during the plan year, your company credit may change accordingly. You are responsible for paying the difference between the amount of your DXC credit and the total premium for the plan you choose. Your portion of the premium will be taken from your gross salary through payroll deductions before federal income taxes are calculated and before state income taxes are calculated (in states where legally permitted). Your pre-tax contributions are governed by and pursuant to the **Pre-Tax Contribution Plan**, which is a component plan of the **Cafeteria Program** described in **Section 14**. However, under existing federal law, coverage for eligible family members must be provided on a post-tax basis if your eligible family members do not qualify as dependents for federal tax purposes. See **Special Definitions Regarding Dependents** in **Section 14, DXC Technology Company Cafeteria Program**.

Claims & Appeals

For information on how to submit a medical insurance claim for benefits or appeal a decision related to a medical insurance claim, please contact the insurance provider directly and reference the providers benefit booklet and certificate of coverage, incorporated herein by reference. The insurance provider is the claims administrator for your medical benefits. Contact information for your medical insurance provider is provided in the back of this Guidebook.

Please keep in mind that a claim for medical benefits is subject to specific deadlines and procedures, all of which are set forth in the carrier's benefit booklet and/or certificate of coverage.

Contacting the Carrier

Contact information for all benefit carriers is provided in the back of this Guidebook and, after you enroll, on your medical plan ID card.

DXC Healthy Behaviors Wellness Program

Introduction

Enrollment in a DXC-sponsored high deductible health plan (HDHP) includes access to the DXC Healthy Behaviors Wellness Program, which is administered by Virgin Pulse. The following medical plans are HDHPs in 2024:

- U.S. Standard Medical Plans: Bronze, Bronze Plus, and Silver

The Healthy Behaviors Program provides you with tools and resources to manage and improve your health and health-related behaviors. Activities and resources include the following:

- **Health Screening:** Complete a biometric screening (e.g., blood pressure, cholesterol, glucose) during the plan year. **Note: Only results for screenings *in* 2024 that are received by the deadline will be accepted for incentive purposes.**
- **Health Check Survey:** Complete self-reported online questionnaire.
- **Next Steps Consult:** Complete a call with a Virgin Pulse health guide to review your Health Screening and Health Check Survey results.
- **Additional Healthy Activities:** Education via daily cards, online journeys or wellness coaching via phone, activity tracking, healthy habit tracking, step and healthy habit challenges.

More information on the DXC Healthy Behaviors Wellness Program is available on the Virgin Pulse website member.virginpulse.com.

Eligibility and Participation in the DXC Healthy Behaviors Wellness Program

Participation in the DXC Healthy Behaviors Wellness Program is not required; however, employee members who want to earn wellness incentives must complete the associated activities in the program (see **Wellness Incentive Program**, below).

Participation of Spouses and Other Dependents: Enrolled spouses are eligible to participate in the Healthy Behaviors Program and access the services provided, but are not eligible to earn the incentives; nor is their participation required for the employee to earn the incentives above.

At present, other dependents, such as children, are not eligible to participate in the Healthy Behaviors Wellness Program.

These participation guidelines also apply to spouses and dependents of former employees enrolled in a high deductible health plan through COBRA.

Participation and Incentive Period: The Healthy Behaviors resources and activities are available year-round; however, the Wellness Activities in the table below must be completed and **received by Virgin Pulse by November 30** of the plan year to earn the company contributions to your tax-favored account. You can complete the activities after November 30 of the plan year, but you will not earn wellness incentives.

Accessing the Healthy Behaviors Wellness Program

To access the Healthy Behaviors Wellness Program, you need to set up an account on the Virgin Pulse portal:

- Go to join.virginpulse.com/DXC
- Provide your first and last name (as it appears on record with DXC) and your date of birth
- If your spouse is covered under one of the DXC high deductible health plans, s/he will be able to set up his/her own account, as well. (Other dependents do not have access to the Healthy Behaviors Wellness Program.)

Wellness Incentive Program

If you complete certain activities in the Healthy Behaviors Wellness Program, DXC will make contributions to your company-sponsored Health Savings Account (HSA). If you have not opened a tax-favored account at the time you first earn wellness incentives or are not eligible to do so, a Health Reimbursement Account (HRA) will be opened for you (see **Section 13, DXC Health Reimbursement Account**). Note

that once an HRA is opened on your behalf, per IRS rules, you will not be able to open an HSA and make contributions during the same plan year. For plan year 2024, the activities and incentive amounts are:

		DXC HSA/HRA Contributions	
Wellness Activity		**Employee Coverage**	**Employee + Dependent(s)**
1	Health Screening	$250	$300
2	Health Check Survey	$70	$70
3	Next-Steps Consult®	$70	$70
5	Additional Healthy Activities	$560 ($140 max. paid per plan year quarter)	$1,060 ($265 max. paid per plan year quarter)
	TOTAL ANNUAL INCENTIVE OPPORTUNITY	**$950**	**$1,500**

Alternative Activities: If you think you will be unable to meet a standard for reward under this wellness program, you may qualify for an opportunity to earn the same reward by different means. Contact Virgin Pulse, which will work with you (and if you wish, with your doctor) to find a wellness program with the same reward that is right for you in view of your health status.

Deadline: The deadline for completing the activities to earn wellness incentives for the 2024 Plan Year is **November 30, 2024**. All activities, including health screen results, must be received by Virgin Pulse by the deadline.

General Information About the Wellness Incentives: Please note the following about the wellness activities for 2024:

- While it is not mandatory that the wellness activities be completed in a particular order, to fully benefit from the program, it is recommended that they be completed in the order in which they appear in the chart.
- For the vast majority of activities, you do not need to achieve a certain outcome to earn an incentive; you just need to complete the activity.
- You do not need to complete all of the wellness activities to earn the incentives; each activity is "priced" and paid out separately as it is completed, with the exception of the additional healthy activities (see below).
- Employees joining DXC during the plan year are only eligible to earn Program Participation incentives for the quarters in which they are employed; e.g., an employee hired on April 15, who elected Employee Only coverage, would be eligible for $420 (3 x $140) of the $560 Program Participation incentives that plan year.
- If an employee is covering one or more dependents on his/her medical plan, only the employee member needs to complete the wellness activities to earn the incentives (see above, **Participation of Spouses and Other Dependents**) and only the employee is eligible to *earn* incentives. If enrolled in COBRA, only the former employee needs to complete the wellness activities and is eligible to *earn* incentives.
- Incentive amounts are paid based on the enrollment status (i.e., employee only vs. employee + dependent[s]) that Virgin Pulse has on file for you on the date the wellness activity is completed.
- Wellness incentives count towards the IRS annual contribution limit. Be sure to take into account any incentives you think you will earn when you enroll in an HSA.

Description of Wellness Incentive Activities

Personal Health Screening: The personal health screening activity requires that you undergo a basic health screening that captures five pieces of data:

1. Height
2. Weight
3. Blood Pressure
4. Glucose
5. Cholesterol

You can complete a personal health screening in one of several ways:

- Use a voucher issued by Virgin Pulse to get a health screening through one of Virgin Pulse's screening partners, e.g. LabCorp, CVS Minute Clinic, which include walk-in clinics at several national retail chains; or
- Take a Physician Form to a provider in your DXC medical plan's network (e.g., primary care physician or a walk-in clinic, including those located in major retail chains) to perform the tests and complete the form; then submit the form directly to Virgin Pulse; or
- Request a Pixel Home Test Kit

Please visit the Virgin Pulse website at member.virginpulse.com for more information on the Health Screening.

Health screening results **must be received by November 30, 2024** for you to earn the applicable incentives. Makesure you plan accordingly, as providers can be slow in submitting screening results.

Health Check Survey: The Health Check Survey is a brief questionnaire regarding your health and well-being. It can be completed online via the Virgin Pulse portal at member.virginpulse.com. Once you complete the Health Screening, that data will auto-populate within the questionnaire; however, you do not need to complete the Health Screening before completing the Health Check Survey. If you do not have Internet access, you can obtain a paper copy of the Health Check Survey by calling Virgin Pulse at: 1.855.824.6440.

Next-Steps Consult®: The Next-Steps Consult is a brief, 15-20 minute call to review and discuss the results of your Health Screening and Health Check Survey. A health guide can help you identify wellness goals, and explain and recommend the Virgin Pulse programs that might help you achieve these goals. Please visit the Virgin Pulse website at member.virginpulse.com to schedule a call with a Health Guide.

Additional Healthy Activities provide education via daily cards, online journeys or wellness coaching via phone, activity tracking, healthy habit tracking, step and healthy habit challenges.

You can earn up to $560 ($140 per quarter) if you have Employee coverage or $1,060 ($265 per quarter) if you have Employee + Dependent coverage, by completing program activities.

Ideal or Improved Measurements: Points can be earned for the following Ideal or Improved Measurements:

Factor	Incentive Standard	Program Points Available
Target Body Mass Index (BMI)	18.5 – 24.999 5%	150
Target Blood Pressure	<120/80 mmHg	150
Target Total Cholesterol	<220	150

Note: The 150 points available for having target or improved numbers are part of the total Program activity dollars available to you ($500 if you have Employee coverage or $1,000 if you have Employee +1 or Family coverage), not in addition to it.

If you do not have results from the Health Screening that are sufficient to earn the points associated with having target or improved measurements (measurements must improve by 5% from the last measurement), there are plenty of other ways to earn points that are not based on outcome. There is a broad menu of ways to earn all of your program incentives. Please visit the Virgin Pulse website at member.virginpulse.com for more information on their programs.

Payment of Wellness Incentives

Wellness incentives will be paid in the form of company contributions to your company sponsored Health Savings Account (HSA). Wellness incentives count towards the IRS annual contribution limit. Be sure to take those wellness incentives into account when you enroll in your HSA so you don't exceed the IRS maximum.

If you do not enroll or re-enroll in a DXC HSA for the current year, a Health Reimbursement Account (HRA) will be established for you and incentives credited there (See **Section 13, DXC Health Reimbursement Account**).

Although you can open an HSA through the DXC Benefits Center site (myDXCbenefitscenter.com) at any time,or by contacting the DXC Benefits Center at 1.888.305.5499, it's important that you open your HSA before earning any wellness incentives because once an HRA is established, per IRS rules, you will not be able to open an HSA and make contributions during the same plan year.

Incentives are credited to your account after a reasonable processing time (approximately 1 to 3 weeks) as you complete each associated Wellness Activity. However, the incentive for your Health Screening incentives can take longer, so be sure to allow sufficient time before the November 30 deadline.

Wellness Program Privacy Notice

The DXC Healthy Behaviors Wellness Program, administered by Virgin Pulse, is a voluntary wellness program available to all employees enrolled in a DXC sponsored high deductible health plan as defined by the Internal Revenue Service. The program is administered according to federal rules permitting employer sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health assessment that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a Health Screening, which will include a test for blood glucose, cholesterol, and blood pressure.

You are not required to complete the Health Assessment, or to participate in the blood test, other medical examinations, or other wellness activities. However, colleagues who choose to participate in these wellness activities will receive an incentive of up to $950 per year (and up to $1,500 per year for employees covering a spouse or dependent[s]). Although you are not required to participate in the Health Screening, only employees who do so will receive program participation incentives for their Ideal or Improved Measurements. Alternative ways to earn the program incentives are available. Program details can be found above under **Description of Wellness Incentive Activities** and on the Virgin Pulse portal member.virginpulse.com.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Virgin Pulse at 1.855.824.6440. The information from your Health Check Survey and the results from your Health Screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching or specific Virgin Pulse Journeys. You also are encouraged to share your results or concerns with your own doctor.

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

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are health guides assigned to you through the opt-in Virgin Pulse health coaching program. In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Your individual medical information is not shared with DXC. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact DXC by submitting a request to Employee Connect: https://dxchr.service-now.com/hrportal or contact Virgin Pulse via their portal member.virginpulse.com or by phone 1.855.824.6440.

Contacting the Administrator

Contact information for all benefit carriers and administrators is provided in the back of this Guidebook.

Medical Benefits for Employees Residing in Hawaii

Introduction

Medical benefits for employees residing in Hawaii are offered through the Aon Active Health Exchange™ (Aon Exchange). The Plans available on the Aon Exchange for employees in Hawaii are:

- Kaiser Gold
- HMSA Gold
- Kaiser Platinum
- HMSA Platinum

A high-level summary of benefits available under these plans is provided below. In the event of a conflict between the benefits described here, and benefits described in the applicable carrier's Certificate of Coverage, the Certificate of Coverage shall control.

Additional Eligibility Requirements

In addition to meeting the general eligibility requirements outlined starting on page 2-1, you must reside within the state of Hawaii to be eligible for the medical benefits described here.

Benefits Provided

A high-level summary of the benefits is provided in the table on the following page. Contact your carrier directly for more detailed information and/or questions related to a specific medical condition or treatment.

Covering Dependents

The following coverage tiers are available for the Aon Exchange medical plans:

- Employee only
- Employee + Spouse
- Employee + Child(ren)
- Family (Employee, Spouse and Child(ren))

Cost of Participation in the Plan

There are two components to the cost of participation in medical plans offered through the Aon Exchange: the total insurance premium and the company credit or subsidy.

Insurance Premiums: All Aon Exchange plans are fully insured by the carriers; therefore, the carriers underwrite and price the plans. You will be able to see the plan premiums when you log on to myDXCbenefitscenter.com.

Company Credit: DXC will provide you with a credit with which you can purchase DXC medical benefits. (Note: This credit can only be used for the purchase of DXC medical benefits.) The amount of credit you receive will be based on the following factors:

- Geographic pricing region in which you reside (i.e., Hawaii);
- Whether your annual salary is less than $75,000 or is $75,000 or greater; and
- Coverage tier (e.g., Employee, Family).

You will be able to see your credit amount when you log into the DXC Benefits enrollment portal (myDXCbenefitscenter.com). You are responsible for paying the difference between the amount of your DXC credit and the total premium for the plan you choose. Your portion of the premium will be taken from your gross salary through payroll deductions before federal income taxes are calculated and before state income taxes are calculated (in states where legally permitted). Your pre-tax contributions are governed by and pursuant to the **Pre-Tax Contribution Plan**, which is a component plan of the **DXC Technology Company Cafeteria Program** described in **Section 14**. However, under existing federal law, coverage

for eligible family members must be provided on a post-tax basis if your eligible family members do not qualify as dependents for federal tax purposes. See **Special Definitions Regarding Dependents** in **Section 14, DXC Technology Company Cafeteria Program**.

Claims & Appeals

For information on how to submit a medical insurance claim for benefits or appeal a decision related to a medical insurance claim, please contact the insurance provider directly and reference the providers benefit booklet and certificate of coverage, incorporated herein by reference. The insurance provider is the claims administrator for your medical benefits. Contact information for your medical insurance provider is provided in the back of this Guidebook.

Please keep in mind that a claim for medical benefits is subject to specific deadlines and procedures, all of which are set forth in the carrier's benefit booklet and/or certificate of coverage.

Contacting the Carrier

Contact information for all benefit carriers is provided in the back of this Guidebook and, after you enroll, on your medical plan ID card.

Hawaii Medical Plans: Summary of In-Network Benefits

Service	HMSA Gold	Kaiser Gold	HMSA Platinum	Kaiser Platinum
Plan Type	PPO	HMO	PPO	HMO
Deductible[1] (individual/with dependents)	$200/$600	$200/$400	$0/$0	$0/$0
Coinsurance	80% or 90% after deductible	80% or 90% after deductible	80% or 90%	80% or 90%
Office Visit – Primary Physician	$12 member copay after deductible	$15 member copay	$12 member copay	$15 member copay
Office Visit – Specialist	$12 member copay after deductible	$15 member copay	$12 member copay	$15 member copay
Preventive Care	100% (no deductible)	100% (no deductible)	100%	100%
Emergency Room	80% after deductible	80% (no deductible)	80% after deductible	$75 member copay
In-Patient Hospital	Covered 80% after deductible	90% after deductible	90%	$75 member copay per day then 100% covered
Annual Out-of-pocket maximum (Individual/with Dependents)	$2,200/$6,600	$2,200/$4,400	$2,500/$7,500	$2,500/$7,500
Prescription Drugs – Retail (30-day supply)				
Tier 1	$7 member copay	$10 member copay	$5 member copay	$10 member copay
Tier 2	$35 member copay	$35 member copay	$30 member copay	$35 member copay
Tier 3	$75 member copay	Not covered	$70 member copay	Not covered
Prescription Drugs – Mail Order(90-day supply)				
Tier 1	$14 member copay	$20 member copay	$10 member copay	Generic maintenance: $20 member copay
Tier 2	$70 member copay	$70 member copay	$60 member copay	$70 member copay
Tier 3	$150 member copay	Not covered	$140 member copay	Not covered
Prescription Drug Annual out-of-pocket maximum	$3,000/$7,200	Part of medical OOPM	$3,000/$5,700	Part of medical OOPM

Service	HMSA Gold	Kaiser Gold	HMSA Platinum	Kaiser Platinum
Plan Type	PPO	HMO	PPO	HMO
(Individual/With Dependents)	(combined in- and out-of-network)		(combined in- and out-of-network)	

1. Prescription drug spend does not apply toward the deductible for Hawaii plans

Hawaii Medical Plans: Summary of Out-of-Network Benefits

Service	HMSA Gold[1]	Kaiser Gold	HMSA Platinum[1]	Kaiser Platinum
Plan Type	PPO	HMO	PPO	HMO
Deductible[2] (individual/with dependents)	$200/$600 (combined with in-network)	Not available	$100/$300	Not available
Coinsurance	80% or 90% after deductible		70% or 80%	
Office Visit – Primary Physician	$12 member copay after deductible		70% after deductible	
Office Visit – Specialist	$12 member copay after deductible		70% after deductible	
Preventive Care	100% (no deductible)		70% after deductible	
Emergency Room	80% after deductible		80% (no deductible)	
In-Patient Hospital	Covered 80% after deductible		70% after deductible	
Annual Out-of-pocket maximum In-Network (Individual/with Dependents)	$2,200/$6,600 (combined in and out-of-network)		$2,500/$7,500 (combined in- and out-of-network)	
Prescription Drugs – Retail (30-day supply)				
Tier 1	70% covered		80% covered	
Tier 2	70% covered		80% covered	
Tier 3	70% covered		80% covered	
Prescription Drugs – Mail Order (90-day supply)	Not applicable		Not applicable	
Tier 1				
Tier 2				
Tier 3				
Prescription Drug Annual out-of-pocket maximum (Individual/WithDependents)	$3,000/$7,200 (combined in- and out-of-network)		$3,000/$5,700 (combined in- and out-of-network)	

1. May be subject to usual and customary charge limits or other limitations
2. Prescription drug spend does not apply toward the deductible for Hawaii plans

Medical Benefits for Employees Residing in Puerto Rico

Introduction

Medical benefits for employees residing in Puerto Rico are offered through the Aon Active Health Exchange™ PuertoRico (Aon Exchange), which allows employees to select both the plan design as well as the insurance carrier for the plan design they choose. Employees who are eligible for Puerto Rico Medical Benefits may choose from the following plan designs on the Aon Exchange:

- Bronze
- Silver
- Gold
- Platinum

All plans include prescription drug, dental, and vision coverage. Employees may elect either MCS or Triple-S Salud to administer their chosen metallic plan design.

Additional Eligibility Requirements

In addition to meeting the general eligibility requirements outlined starting on page 2-1, you must reside within the Commonwealth of Puerto Rico to be eligible for the medical benefits described here.

Benefits Provided

A high-level summary of benefits available under these plans is provided below. In the event of a conflict between the benefits described here, and benefits described in the applicable carrier's Certificate of Coverage, the Certificate of Coverage shall control. Contact your carrier directly for more detailed information and/or questions related to a specific medical condition or treatment.

Covering Dependents

The following coverage tiers are available for the Aon Exchange medical plans:

- Employee only
- Employee + Spouse
- Employee + Child(ren)
- Family (Employee, Spouse & Child(ren))

Cost of Participation in the Plan

There are two components to the cost of participation in medical plans offered through the Aon Exchange: the total insurance premium and the company credit or subsidy.

Insurance Premiums: All Aon Exchange plans are fully insured by the carriers; therefore, the carriers underwrite and price the plans. You will be able to see the plan premiums when you log on to the DXC Benefits Center portal at myDXCbenefitscenter.com.

Company Credit: DXC will provide you with a credit with which you can purchase DXC medical benefits. (Note: This credit can only be used for the purchase of DXC medical benefits.) The amount of credit you receive will be based on the coverage tier you elect (e.g., Employee, Family).

You will be able to see your credit amount when you log into the enrollment website. You are responsible for paying the difference between the amount of your DXC credit and the total premium for the plan you choose. Your portion of the premium will be taken from your gross salary through payroll deductions before federal income taxes are calculated and before state income taxes are calculated (in states where legally permitted). Your pre-tax contributions are governed by and pursuant to the **Pre-Tax Contribution Plan**, which is a component plan of the **DXC Technology Company Cafeteria Program** described in **Section 14**. However, under existing federal law, coverage for eligible family members must be provided

on a post-tax basis if your eligible family members do not qualify as dependents for federal tax purposes. See **Special Definitions Regarding Dependents** in **Section 14, DXC Technology Company Cafeteria Program**.

Claims & Appeals

For information on how to submit a medical insurance claim for benefits or appeal a decision related to a medical insurance claim, please contact the insurance provider directly and reference the providers benefit booklet and certificate of coverage, incorporated herein by reference. The insurance provider is the claims administrator for your medical benefits. Contact information for your medical insurance provider is provided in the back of this Guidebook.

Please keep in mind that a claim for medical benefits is subject to specific deadlines and procedures, all of which are set forth in the carrier's benefit booklet and/or certificate of coverage.

Contacting the Carrier

Contact information for all benefit carriers is provided in the back of this Guidebook and, after you enroll, on your medical plan ID card.

Puerto Rico Medical Plan: Summary of In-Network Benefits

Service	Bronze	Silver	Gold	Platinum
Plan Type	PPO	PPO	PPO	PPO
Deductible (applies to medical only) (individual/with dependents)	$100/$300[1]	None	None	None
Coinsurance				
Office Visit[2]	$5/$10/$15 copay	$10/$15/$20 copay	$8/$12/$15 copay	$5/$10/$10 copay
Preventive Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Emergency Room	$100 copay sickness $0 copay trauma	$75 copay sickness $0 copay trauma	$50 copay sickness $0 copay trauma	$35 copay sickness $0 copay trauma
In-Patient/Out-Patient Hospital or Facility	Covered 70%	$150 copay	$75 copay	$50 copay
In-Patient – Physician Services	Covered 100% for most services	Covered 100% for most services	Covered 100% for most services	Covered 100% for most services
Out-Patient Surgery – Physician Services	Covered 100%	Covered 100%	Covered 100%	Covered 100%
X-ray/Lab/Specialized Test	Covered 70%	Covered 70%	Covered 75%	Covered 80%
Annual Out-of-pocket maximum (Individual/with Dependents)	$6,350/$12,7007	$6,350/$12,700	$6,350/$12,700	$6,350/$12,700
Prescription Drugs (Level I) (30 Day Retail // 90 Day Supply)	*You pay . . .*	*You pay . . .*	*You pay . . .*	*You pay . . .*
Generic	20%/min $5 // 20%	$8 // 20%	$5 // $10	$5 // $10
Brand – Preferred	20%/min $10 // 20%	20%/min $15 // 20%	20%/max $20 // 20%/max $50	$15 // $30
Brand -- Non-Preferred	40%/min $25 // 40%	40%/min $25 // 40%	20%/min $25/max $75 //40%/max $150	$25 // $50
Specialty	20%/max $200 // n.a.	20%/max $150 // n.a.	20% max $100 // n.a.	20%/max $100 // n.a.
Prescription Drugs (Level II) (applies when total drug claims exceed a certain amount)	40% when $1,200 exceeded	40% when $1,500 exceeded	N/A	N/A

1. Deductible includes prescription drugs
2. Primary Care Physician/Specialist/Subspecialist

Puerto Rico Medical Plan: Summary of In-Network Benefits (Continued)

Dental	Bronze	Silver	Gold	Platinum
Maximum annual benefit per person	$800	$800	$1,000	$1,250
Basic preventive & diagnostic (2x per year)	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Minor restorative (e.g., fillings, periodontics)	Covered 70%	Covered 70%	Covered 70%	Covered 70%
Major Restorative (e.g., implants, oral surgery)	Not covered	Not covered	Covered 50%	Covered 50%
Orthodontia	Not covered	Not covered	Covered 50% up to maximum benefit of $1,000 per lifetime per covered life	Covered 100% up to maximum benefit of $2,000 per lifetime per covered life
Vision				
Eye Exam (1 per year per covered life)	$10 copay	$15 copay	$12 copay	$10 copay
Glasses or elective contact lenses	Covered up to $100 (every 24 months)	Covered up to $100 (every 24 months)	Covered up to $150 (every 24 months)	Covered up to $200 (every 12 months)

Puerto Rico Medical Plan: Summary of Out-of-Network Benefits (Continued)

Service	Bronze[1]	Silver[1]	Gold[1]	Platinum[1]
Plan Type	PPO	PPO	PPO	PPO
Deductible (applies to medical only) (Individual/with dependents)	$100/$300[2]	$2,000/$4,000	$2,000/$4,000	$2,000/$4,000
Coinsurance				
Office Visit	Covered 60%	Covered 60%	Covered 60%	Covered 60%
Preventive Care	Covered 60%	Covered 60%	Covered 60%	Covered 60%
Emergency Room	$100 copay sickness $0 copay trauma	$75 copay sickness $0 copay trauma	$50 copay sickness $0 copay trauma	$35 copay sickness $0 copay trauma
In-Patient/Out-Patient Hospital or Facility	Covered 60%	Covered 60%	Covered 60%	Covered 60%
In-Patient – Physician Services	Covered 60%	Covered 60%	Covered 60%	Covered 60%
Out-Patient Surgery - Physician	Covered 60%	Covered 60%	Covered 60%	Covered 60%
X-ray/Lab/Specialized Test	Covered 60%	Covered 60%	Covered 60%	Covered 60%
Annual Out-of-pocket maximum (Individual/with Dependents)	$6,350/$12,700	$6,350/$12,700	$6,350/$12,700	$6,350/$12,700
Prescription Drugs (Level I) – Retail Only				
Generic	Covered 60%	Covered 60%	Covered 60%	Covered 60%
Brand – Preferred	Covered 60%	Covered 60%	Covered 60%	Covered 60%
Brand -- Non-Preferred	Covered 60%	Covered 60%	Covered 60%	Covered 60%
Specialty	Covered 60%	Covered 60%	Covered 60%	Covered 60%
Prescription Drugs (Level II) (applies when total drug claims exceed a certainamount)	40% when $1,200 exceeded	40% when $1,500 exceeded	N/A	N/A
Dental	**Not Available**	**Not Available**	**Not Available**	**Not Available**
Vision				
Eye Exam (1 per year per covered life)	Covered up to $100	Covered up to $100	Covered up to $150	Covered up to $200
Glasses or elective contact lenses	Covered up to $100 (every 24 months)	Covered up to $100 (every 24 months)	Covered up to $150 (every 24 months)	Covered up to $200 (every 12 months)

1. May be subject to usual and customary charge limits or other limitations.
2. Deductible includes prescription drugs

Triple-S Salud Employee Assistance Program

Medical benefits through Triple-S Salud also include an Employee Assistance Program administered by Inspira Health Management, Inc. This program is in addition to the DXC LifeManagement program administered by Magellan(see **Section 5**, **LifeManagement Program [Employee Assistance Plan]**). Inspira is based in San Juan, P.R. and offers a robust network of local providers for employees. Services include:

- Counseling in:
  - Marital and family issues
  - Parenting and child care
  - Life changes (e.g., divorce, birth, relocation)
  - Grief and loss
  - Substance abuse
  - Elder care
  - Mental health issues
  - Work issues (e.g., interpersonal relationships, performance improvements)
- Child and adolescent services
- Services for the elderly
- Financial counseling
- Legal assistance
- Specialist and community referrals
- Manager support
- Crisis intervention

Counseling services include up to ten sessions per year for the employee and for each eligible dependent. **To arrange counseling call Inspira: 1.800.284.9515.** For more information on Inspira services, visit www.inspirapr.com or send an email to imental@inspirapr.com.

MCS Employee Assistance Program

Medical benefits through MCS also include an Employee Assistance Program called MCS Solutions. This program is in addition to the DXC LifeManagement program administered by Magellan (see **Section 5**, **LifeManagement Program [Employee Assistance Plan]**). MCS Solutions offers:

- 24/7 access to phone consultation services
- Up to eight visits to a counselor with no copayment
- Mental health and substance abuse services (pre-authorization required)

MCS Solutions care coordinators will help identify whether you need a clinical or personalized consultation. If you need clinical assistance, you will be referred to the appropriate clinical services.

MCS Solutions can assist with:

- Depression and anxiety
- Work-related stress
- Coping with changes in your personal life or professional career
- Personal growth and development
- Researching care and alternative therapies for incurable illnesses
- Situations that require financial assistance
- Situations that requires legal assistance

To arrange counseling, call MCS Solutions at 1.866.627.4327. For more information on MCS Solutions services, visit: https://mcs.com.pr/en/Pages/wellness/wellness-programs/mcs-solutions.aspx.

Medical Benefits for Employees on Expatriate Assignment

Introduction

Employees who are assigned to work outside of the U.S. for 180 days or more will cease to be eligible for the standard DXC medical, dental, and vision plans. Instead, the DXC International Benefits Plan will be available to provide similar medical, dental and visions benefits. This plan is provided through Cigna Global Health Benefits (Cigna Global).

Note: Vision and dental benefits are included as part of the medical plan.

Additional Eligibility Requirements

In addition to meeting the general eligibility requirements outlined starting on page 2-1, you must be assigned to work outside of the U.S. for 180 calendar days or more within a consecutive 12-month period to be eligible for the medical benefits described here.

Important Enrollment Information

Your DXC Health Plan Coverage Upon Assignment Outside of the United States

Once the DXC Benefits Center has been advised that you have been assigned to work outside of the United States for 180 calendar days or more within a consecutive 12-month period, you must choose this new medical coverage for yourself and any eligible dependents within 30 calendar days of your change in status to a non-U.S.-based employee.

If you do not select this new medical coverage within 30 days of your change in status, your medical coverage election will default to the DXC International Benefits Plan at the Employee Only coverage level effective on the 31st day following your change in status.

Your DXC Health Plan Coverage Upon Return from Assignment Outside of the United States

Once the DXC Benefits Center has been advised that you are returning from your assignment to work outside of the United States for a period greater than 30 calendar days on any type of leave of absence, you will be notified of your medical options upon your return. Since the DXC International Benefits Plan is not available to U.S.-based employees on U.S. payroll, you will need to choose a new medical, dental, and vision plan for yourself and any eligible dependents within 30 days of your return to the United States.

If you do not select new medical and dental coverage within 30 days of your return to the United States, your medical coverage elections for you and any currently-covered family members will default to the lowest-cost Gold medical plan available to you on the Aon Exchange effective on the 31st day following your return to the United States. If you do not elect new dental or vision coverage within 30 days of your return to the United States, you will be defaulted to waiver of coverage.

Benefits Provided

A high-level summary of the benefits is provided in the following table. The DXC Benefits Center can provide you with a benefits summary for the DXC International Benefits Plan. Contact Cigna Global directly for more detailed information and/or questions related to a specific medical condition or treatment.

In the event of a conflict between the benefits described here, and benefits described in the applicable carrier's Certificate of Coverage, the Certificate of Coverage shall control.

Expatriate Health Plan: Summary of Medical Benefits

Service	International (Outside U.S.)	U.S. In-Network	U.S. Out-of-Network
Deductible[1] (Individual/With Dependents)	None	$200/$600 (embedded)	$600/$1,800 (embedded)
Coinsurance	90% covered	90% covered after deductible	70% covered after deductible
Office Visit – Primary Physician	90% covered	90% covered after deductible	70% covered after deductible
Office Visit – Specialist	90% covered	90% covered after deductible	70% covered after deductible
Preventive Care	100% covered	100% covered (no deductible)	60% covered (no deductible)
Urgent Care	90% covered	90% covered after deductible	90% covered after deductible (if not a true emergency, 70% covered after deductible)
Emergency Room Visit	100% covered	$125 member copay; then 100% covered after deductible	$125 member copay; then 100% covered after deductible (if not a true emergency, 80% covered after deductible)
In-Patient Hospital	90% covered	90% covered after deductible	70% covered after deductible
Annual Out-of-pocket maximum (Individual/with Dependents)	$2,500/$5,000	$2,500/$5,000	$2,500/$5,000
Prescription Drugs – Retail (30-day supply)			
Tier 1 (Generic)	90% covered	$10 member copay	80% covered after deductible
Tier 2 (Preferred Brand)	90% covered	$30 member copay	80% covered after deductible
Tier 3 (Non-Preferred Brand)	90% covered	$30 member copay	80% covered after deductible
Prescription Drugs – Mail Order (90-day supply)			
Tier 1 (Generic)	Not available	$30 member copay	Not available
Tier 2 (Preferred Brand)	Not available	$90 member copay	Not available

Service	International (Outside U.S.)	U.S. In-Network	U.S. Out-of-Network
Tier 3 (Non-Preferred Brand)	Not available	$90 member copay	Not available

Note that Cigna has Step Therapy and Prior Authorization requirements for certain medications. You can review Cigna's drug list by visiting www.cigna.com/druglist and electing "Performance 3 Tier" from the drug list drop down menu.

Expatriate Health Plan: Summary of Dental and Vision Benefits

Service	International (Outside U.S.)	U.S. In-Network	U.S. Out-of-Network
Dental Benefits			
Deductible (individual/family)	$50/$150	$50/$150	$50/$150
Maximum Annual Benefit (excluding orthodontia)	$2,000 per covered life	$2,000 per covered life	$2,000 per covered life
Preventive Services	100% covered (no deductible)	100% covered (no deductible)	100% covered (no deductible)
Minor Restorative (fillings, extractions)	80% covered after deductible	80% covered after deductible	80% covered after deductible
Major Restorative (crowns, dentures, bridges)	50% covered after deductible	50% covered after deductible	50% covered after deductible
Orthodontics (children only)			
Coverage	50% covered (no deductible)	50% covered (no deductible)	50% covered (no deductible)
Lifetime Max. Benefit	$1,500 per covered life	$1,500 per covered life	$1,500 per covered life
Vision Benefits			
Routine vision exam (every 12 months)	$80 allowance	100% after $10 member copay ($80 maximum benefit)	70% covered after deductible ($80 maximum benefit)
Lenses & Frames or contact lenses (every 24 months)	$130 allowance	$130 allowance	$130 allowance

1. Accrual towards deductibles and annual out-of-pocket maximums cross-apply to International, U.S. In-Network and U.S Out- of-Network.

Covering Dependents

The following coverage tiers are available for the DXC International Benefits Plan:

- Employee only
- Employee + Spouse
- Employee + Child(ren)
- Family [Employee, Spouse and Child(ren)]

Cost of Participation in the Plan

You will be able to see your share of the cost of participating in the plan when you log into the DXC Benefits portal at myDXCbenefitscenter.com. Your contributions will be taken from your gross salary through payroll deductions before federal income taxes are calculated and before state income taxes are calculated (in states where legally permitted). Your pre-tax contributions are governed by and pursuant to the **Pre-Tax Contribution Plan**, which is a component plan of the **DXC Technology Company Cafeteria Program** described in **Section 14**.However, under existing federal law, coverage for eligible family members must be provided on a post-tax basis if your eligible family members do not qualify as dependents for federal tax purposes. See **Special Definitions Regarding Dependents** in **Section 14, DXC Technology Company Cafeteria Program**.

Filing a Claim

Please refer to the current benefits booklet/certificate of coverage (incorporated by reference herein) for the DXC International Benefits Plan.

Contacting the Carrier

Contact information for all benefit carriers is provided in the back of this Guidebook and, after you enroll, on your medical plan ID card.

Claims & Appeals

For information on how to submit a medical insurance claim for benefits or appeal a decision related to a medical insurance claim, please contact the insurance provider directly and reference the providers benefit booklet and certificate of coverage, incorporated herein by reference. The insurance provider is the claims administrator for your medical benefits. Contact information for your medical insurance provider is provided in the back of this Guidebook.

Please keep in mind that a claim for medical benefits is subject to specific deadlines and procedures, all of which are set forth in the carrier's benefit booklet and/or certificate of coverage.

Termination Of Coverage

Conditions Under Which Coverage Terminates

Coverage under your DXC medical plan ends for you and your covered family members (see also **Additional Conditions When Family Member Coverage Terminates**) on the earliest of the following dates:

- You stop making required contributions in accordance with plan provisions
- You fail to make premium payments while on an approved leave of absence (see **Section 14, DXC Technology Company Cafeteria Program**, **Continuation of Coverage** and the **DXC U.S. Leaves of Absence with Pay** and **DXC U.S. Leaves of Absence without Pay** (available on Employee Connect))You elect medical care through a different company-offered medical plan
- Your employment with DXC ends (except see **Section 6, COBRA Rights**)
- You no longer meet the definition of an eligible employee (except see **Section 6, COBRA Rights)**
- You are terminated from coverage for cause as defined by your insurance carrier or employer
- The plan ends

Also see Section 14, DXC Technology Company Cafeteria Program, Period of Coverage. The same provisions also apply to this benefit plan.

Continuation of Coverage

If you are eligible for medical benefits at the time of termination of employment with DXC, you may be eligible to continue coverage as authorized under **Section 6, COBRA Rights**. The same provisions apply to this benefit plan.

Additional Conditions When Family Member Coverage Terminates

In addition to the conditions above, family member coverage ends on the earliest of the following dates:

- Your spouse is no longer an eligible family member by reason of legal separation or divorce (except see **Section 6, COBRA Rights**)
- Your dependent child is no longer an eligible family member as defined in this section under **Family Eligibility for Medical Plans** (except see **Section 6, COBRA Rights**)
- Your dependent child becomes covered as an employee of DXC, a DXC subsidiary or DXC affiliate
- Upon your failure to satisfy any dependent verification requests

Also see Section 14, DXC Technology Company Cafeteria Program, Period of Coverage. The same provisions also apply to this benefit plan.

Section 3

Dental Plans

Dental Plans

General Information, Eligibility, & Enrollment

DXC offers dental plans to you and your eligible family members. All plans are administered by the DXC Benefits Center managed by Businessolver.

For convenient reference in this Guidebook, the coverage options are described as separate plans. These benefits are provided through a sub-part of the ERISA plan through which other benefits are provided (such as other medical and vision coverages). That ERISA Plan is plan number 502.

For a list of employers participating in the overall ERISA Plan of which this coverage is a part, see **Section 15, ERISA Information**. Section 15 shows whether a participating employer offers a particular plan to its employees. Not all employers offer the same coverage, or all of these plans. Also, some participating employers only offer this coverage to certain employee groups. See **Section 15, ERISA Information,** for more information.

Employee and Dependent Eligibility

For dental coverage, you and your family members are subject to the same provisions and definitions regarding eligibility as set forth in **Section 2, Medical Plans.**

If you elect employee coverage, you may also elect to cover your eligible family members under the same plan.

Verification of Eligibility for Family Coverage

For dental coverage, family members are subject to the same eligibility verification standards set forth in **Section 2, Medical Plans.**

Enrollment/Effective Date of Coverage

Enrolling in Dental Coverage

For dental coverage, you and your eligible dependents are subject to the same provisions regarding enrollment, consequences for failing to enroll, and effective date of coverage set forth in **Section 2, Medical Plans**.

Annual Benefits Open Enrollment/Changing Your Elections

Annual Benefits Open Enrollment Period

For dental coverage, you and your eligible dependents are subject to the same provisions regarding Annual Benefits Enrollment as set forth in **Section 2, Medical Plans**.

Changing Your Elections

See **Section 14, DXC Technology Company Cafeteria Program under Changing Your Cafeteria Plan Elections**.

The same provisions also apply to this benefit plan.

Cost of Participation in the Plan

Your Contributions

The cost of participating in dental benefits is available on the DXC Benefits enrollment site when you are ready to enroll.

Pre-Tax Contribution for Dental Coverage

Your contributions for your elected dental coverage will be taken from your gross salary through payroll deductions before federal income taxes are calculated and before state income taxes are calculated (in states where legally permitted). Your pre-tax contributions are governed by and pursuant to the **Pre-Tax Contribution Plan**, which is a component plan of the **DXC Technology Company Cafeteria Program** described in **Section 14**. However, under existing federal law, coverage for eligible family members must be provided on a post-tax basis if your eligible family members do not qualify as dependents for federal tax purposes. See **Special Definitions Regarding Dependents** in **Section 14, DXC Technology Company Cafeteria Program**.

Dental Claims Administrator

Your insurance carrier is the claims administrator for your dental coverage.

Benefits Provided

Introduction

Employees who reside within the United States, **including the state of Hawaii**, should refer to the provision in **Section 3 titled Standard U.S. Dental Benefits**.

Employees who reside in Puerto Rico receive dental benefits through their medical plan; therefore, they should refer to the provision in **Section 2** titled **Medical Benefits for Employees Residing in Puerto Rico**.

Employees who reside in the U.S. Virgin Islands receive their dental benefits through their medical plan; therefore,they should refer to the provision in **Section 2** titled **Medical Benefits for Employees on Expatriate Assignment** as the same benefits apply to them**.**

Employees who are assigned to work outside the U.S. for 180 days or more during a consecutive 12-month period receive their dental benefits through their medical plan; therefore, they should refer to the provision in **Section 2** titled **Medical Benefits for Employees on Expatriate Assignment**.

Standard U.S. Dental Benefits

Introduction

Standard U.S. dental benefits are offered through the Aon Active Health Exchange™ (Aon Exchange), which allows employees to select both the plan design as well as the insurance carrier for the plan design they elect. Employees may choose from the following plan designs on the Aon Exchange:

- Bronze
- Silver
- Gold
- Platinum (Dental HMO (DHMO), not available in all areas)

Although the Bronze, Silver and Gold plans provide coverage for out-of-network rate, you will receive discounted rate and pay less out of pocket when you receive care from dental care providers in the carrier's network.

A summary of these plans is provided below. In the event of a conflict between the benefits described here and benefits described in the applicable carrier's Certificate of Coverage, the Certificate of Coverage shall control.

Participating Carriers

The following carriers are participating in the Aon Exchange during the 2024 plan year:

- Aetna
- Cigna
- Delta Dental of VA (Bronze, Silver and Gold)
- DeltaCare USA (Platinum)
- MetLife
- UnitedHealthcare

Additional Eligibility Requirements

In addition to meeting the general eligibility requirements outlined starting on page 3-1, you must reside within the United States to be eligible for Standard U.S. Dental Benefits.

Covering Dependents

The following coverage tiers are available for the Aon Exchange dental plans:

- Employee only
- Employee + Spouse
- Employee + Child(ren)
- Family (Employee and Spouse and Child[ren])

Benefits Provided

A high-level summary of the benefits is provided in the following table. With the exception of the Platinum plan, each "metallic" plan is generally the same across all carriers. However, there may be some differences in how each carrier administers the plan. Contact your carrier directly for more detailed information and/or questions related to a specific dental condition or treatment.

U.S. Standard Dental Plans: Summary of Benefits (Applies to both in- and out-of-network)

Features	Bronze	Silver	Gold	Platinum
Annual Deductible (Individual/Family)	$100/$300	$100/$300	$50/$150	Dental HMO (DHMO) • In-network coverage only • Not available in all areas • Plan design varies by carrier
Maximum Annual Benefit (excluding orthodontia)	$1,000 per covered person	$1,500 per covered person	$2,500 per covered person	
Lifetime Maximum for Orthodontia	Not covered	$1,500 per child	$2,000 per person	
Preventive Care	100% covered Deductible waived	100% covered Deductible waived	100% covered Deductible waived	
Minor Restorative Care (e.g., root canal treatment, gum disease treatment and oral surgery)	80% covered After deductible. You pay 20% after deductible.	80% covered After deductible. You pay 20% after deductible.	80% covered After deductible. You pay 20% after deductible.	
Major Restorative Care (e.g., implants, dentures, etc.)	Not covered	60% covered After deductible. You pay 40% after deductible.	80% covered After deductible. You pay 20% after deductible.	
Orthodontia	Not covered	50% covered, You pay 50%; Deductible waived. Only for children up to age 19.	50% covered, You pay 50%; Deductible waived. Applicable to children and adults.	

Important information about the Platinum Plan: The Platinum plan is a dental HMO (DHMO) with in-network benefits only and is not available in all parts of the country. The networks are very limited in some areas**. Before enrolling, please review the availability of dentists participating in the insurance carrier's Platinum network in your area to confirm that you will be satisfied with your access to dental care.** You must elect a primary care dentist from the insurance carrier's Platinum network and have all of your care from or coordinated by that dentist. If you receive services from another provider, even one who is in network, you will be required to pay the full cost of those services. Remember that you can only change your plan elections during Annual Enrollment or if you have a qualifying change of status. See **Changing Your Cafeteria Plan Elections** under **Section 14, DXC Technology Company Cafeteria Program**.

Cost of Participation in the Plan

There are two components to the cost of participation in dental plans offered through the Aon Exchange: the total insurance premium and the company credit or subsidy.

Insurance Premiums: All Aon Exchange plans are fully insured by the carriers. With the exception of the Platinum plan, the carriers underwrite and price the dental plans on a national basis. This means that the price you pay for a dental plan will vary based on the plan design, coverage tier, and carrier you select; it will not vary based on your state of residence. The Platinum plans are priced based on the region in which they are available. You will be able tosee the premiums for the plans available to you when you log on to myDXCbenefitscenter.com.

Company Credit: DXC will provide you with a credit with which you can purchase DXC dental benefits. (Note: This credit can only be used for the purchase of DXC dental benefits.) The amount of credit you receive will be based on the coverage tier (e.g., Employee, Family) you select. You will be able to see your credit amount when you log into the enrollment site. You are responsible for paying the difference between the amount of your DXC credit and the total premium for the plan you choose. Your portion of the premium will be deducted from your biweekly pay on a pre-tax basis. Your pre-tax contributions are governed by and pursuant to the **Pre-Tax Contribution Plan**, which is a component plan of the **DXC Technology Company Cafeteria Program** described in **Section 14**. However, under existing federal law, coverage for eligible family members must be provided on a post-tax basis if your eligible family members do not qualify as dependents for federal tax purposes. See **Special Definitions Regarding Dependents** in **Section 14, DXC Technology Company Cafeteria Program**.

Contacting the Carrier

Contact information for all benefit carriers is provided in the back of this Guidebook.

Claims & Appeals

For information on how to submit a dental insurance claim for benefits or appeal a decision related to a dental insurance claim, please contact the insurance provider directly and reference the providers benefit booklet and certificate of coverage, incorporated herein by reference. The insurance provider is the claims administrator for your dental benefits. Contact information for your dental insurance provider is provided in the back of this Guidebook.

Please keep in mind that a claim for dental benefits is subject to specific deadlines and procedures, all of which are set forth in the carrier's benefit booklet and/or certificate of coverage.

Termination Of Coverage

Conditions Under Which Coverage Terminates

For dental coverage, you and your eligible dependents are subject to the same coverage termination provisions set forth in **Section 2, Medical Plans**.

Section 4

Vision Plans

Vision Plans

General Information, Eligibility, & Enrollment

DXC offers vision benefits to you and your eligible family members. All plans are administered by the DXC Benefits Center managed by Businessolver.

For convenient reference in this Guidebook, the coverage options are described as separate plans. These benefits are provided through a sub-part of the ERISA plan through which other benefits are provided (such as other medical and dental coverages). That ERISA Plan is plan number 502.

For a list of employers participating in the overall ERISA Plan of which this coverage is a part, see **Section 15, ERISA Information**. Section 15 shows whether a participating employer offers a particular plan to its employees. Not all employers offer the same coverage, or all of these plans. Also, some participating employers only offer this coverage to certain employee groups. See **Section 15, ERISA Information,** for more information.

Employee and Dependent Eligibility

For vision coverage, you and your family members are subject to the same eligibility provisions and definitions set forth in **Section 2, Medical Plans**.

Verification of Eligibility for Family Coverage

For vision coverage, you and your family members are subject to the same eligibility verification requirements set forth in **Section 2, Medical Plans**.

Enrollment/Effective Date of Coverage

Enrolling in Vision Coverage

For vision coverage, you and your eligible dependents are subject to the same provisions regarding enrollment, consequences for failing to enroll, and effective date of coverage set forth in **Section 2, Medical Plans**.

Annual Benefits Open Enrollment/Changing Your Elections

Annual Benefits Open Enrollment Period

For vision coverage, you and your eligible dependents are subject to the same provisions regarding Annual Benefits Enrollment as set forth in **Section 2, Medical Plans**.

Changing Your Elections

See **Section 14, DXC Technology Company Cafeteria Program under Changing Your Cafeteria Plan Elections.** The same provisions also apply to this benefit plan.

Cost of Participation in the Plan

Your Contributions

Vision is an entirely employee-paid benefit. Information about how plans are priced is available in the **Benefits Provided** section, below. The cost of participating in vision benefits is available at myDXCbenefits.com.

Pre-Tax Contribution for Vision Coverage

Your contributions for your elected vision coverage will be taken from your gross salary through payroll deductions before federal income taxes are calculated and before state income taxes are calculated (in states where legally permitted). Your pre-tax contributions are governed by and pursuant to the **Pre-Tax Contribution Plan**, which is a component plan of the **DXC Technology Company Cafeteria Program** described in **Section 14**. However, under existing federal law, coverage for eligible family members must be provided on a post-tax basis if your eligible family members do not qualify as dependents for federal tax purposes. See **Special Definitions Regarding Dependents** in **Section 14, DXC Technology Company Cafeteria Program**.

Vision Claims Administrator

Your insurance carrier is the claims administrator for your vision coverage.

Identification Card

Most vision carriers do **not** issue identification cards to their members. Inform your vision service provider of your vision carrier name (e.g., VSP, United, etc.); the vision service provider will be able to verify eligibility, plan coverage, and obtain authorization for services. Upon completion of the appointment, the vision service provider submits the claim to the vision carrier for processing and the carrier pays the provider directly.

Benefits Provided

Introduction

Employees who reside within the United States, **including the state of Hawaii**, should refer to the provision in **Section 3** titled **Standard U.S. Vision Benefits**.

Employees who reside in Puerto Rico receive vision benefits through their medical plan; therefore, they should refer to the provision in **Section 2** titled **Medical Benefits for Employees Residing in Puerto Rico**.

Employees who reside in the U.S. Virgin Islands receive their vision benefits through their medical plan; therefore, they should refer to the provision in **Section 2** titled **Medical Benefits for Employees on Expatriate Assignment** as the same benefits apply to them**.**

Employees who are assigned to work outside the U.S. for 180 days or more during a consecutive 12-month period receive vision benefits through their medical plan; therefore, they should refer to the provision in **Section 2** titled **Medical Benefits for Employees on Expatriate Assignment**.

Standard U.S. Vision Benefits

Introduction

Standard U.S. vision benefits are offered through the Aon Active Health Exchange™ (Aon Exchange), which allows employees to select both the plan design as well as the insurance carrier for the plan design they elect. Employees may choose from the following plan designs on the Aon Exchange:

- Bronze
- Silver
- Gold

A summary of these plans is provided below. In the event of a conflict between the benefits described here and benefits described in the applicable carrier's Certificate of Coverage, the Certificate of Coverage shall control.

Participating Carriers

The following carriers are participating in the Aon Exchange during the 2024 plan year:

- EyeMed
- MetLife
- UnitedHealthcare
- VSP

Additional Eligibility Requirements

In addition to meeting the general eligibility requirements outlined starting on page 4-1, you must reside within the United States to be eligible for Standard U.S. Vision Benefits.

Covering Dependents

The following coverage tiers are available for the Aon Exchange vision plans:

- Employee only
- Employee + Spouse
- Employee + Child(ren)
- Family (Employee and Spouse and Child[ren])

Benefits Provided

A high-level summary of the benefits is provided in the following table. With the exception of the Bronze plan, each "metallic" plan is generally the same across all carriers. However, there may be some differences in how each carrieradministers the plan. Contact your carrier directly for more detailed information and/or questions related to a specificvision condition or treatment.

U.S. Standard Vision Plans: In-Network Benefits

Features	Bronze	Silver	Gold
Benefit Frequency (exam, frames, lenses)	Once per calendar year	Once per calendar year	Once per calendar year
Routine vision exam	Covered in full	$20 member copay	$10 member copay

Features	Bronze	Silver	Gold
Frame allowance	Discounts may apply – Check with carrier	$130 allowance[1]	$200 allowance[1]
Lenses Single Vision Bifocal Trifocal Standard Progressive Lenticular[2]	Discounts may apply - Check with carrier	$20 member copay $20 member copay $20 member copay $20 member copay $20 member copay $20 member copay	$10 member copay $10 member copay $10 member copay $10 member copay $10 member copay $10 member copay
Lens Enhancements: UV Treatment Tint (solid or gradient) Standard plastic scratch coating Standard anti-reflective coating Standard polycarbonate – Adults Standard polycarbonate – Children Other Add-ons	Discounts may apply – Check with carrier	$15 member copay $15 member copay $15 member copay $45 member copay $40 member copay $0 member copay Discounts only	$15 member copay $15 member copay $15 member copay $45 member copay $15 member copay $0 member copay Discounts only
Contact lenses Medically necessary Elective (in lieu of glasses) Fit and evaluation	Not covered Not covered Discounts may apply – Check with carrier	$20 member copay $130 allowance[1] $20 copay	$10 member copay $200 allowance[1] $10 copay
Laser surgery	Check with carrier for discount details	Check with carrier for discount details	Check with carrier for discount details

1) Allowance can be used for frames or elective contact lenses, but not both.
2) Vision benefits are for standard progressives. Enhanced progressives may cost more and will vary by insurance carrier.

U.S. Standard Vision Plans: Out-of-Network Benefits

Features	Bronze	Silver	Gold
Routine vision exam	$45 allowance	$45 allowance	$45 allowance
Frame allowance	Not covered	$70 allowance	$70 allowance
Lenses Single Vision Bifocal Trifocal Standard Progressive Lenticular	Not covered	$30 allowance $45 allowance $55 allowance $45 allowance $90 allowance	$30 allowance $45 allowance $55 allowance $45 allowance $90 allowance
Lens Options UV Treatment Tint (solid or gradient) Standard plastic scratch coating Standard anti-reflective coating Standard polycarbonate – Adults Standard polycarbonate – Children Other Add-ons	Not covered	Not covered	Not covered

Features	Bronze	Silver	Gold
Contact lenses Medically necessary Elective (in lieu of glasses) Fit and evaluation	Not covered Not covered Not covered	$200 allowance $70 allowance Not covered	$200 allowance $70 allowance Not covered
Laser surgery	Not covered	Not covered	Not covered

Important information about the Bronze Plan: The Bronze plan covers an annual eye exam, and provides limited coverage for materials, such as frames and lenses. Unlike the Silver and Gold plans, the benefits under the Bronze plan vary across the carriers. If you are interested in the Bronze plan, it is important that you review the detailed plan features that are provided at myDXCbenefits.com or contact the carrier directly for more information.

Contacting the Carrier

Contact information for all benefit carriers is provided in the back of this Guidebook.

Claims & Appeals

For information on how to submit a vision insurance claim for benefits or appeal a decision related to a vision insurance claim, please contact the insurance provider directly and reference the providers benefit booklet and certificate of coverage, incorporated herein by reference. The insurance provider is the claims administrator for your vision benefits. Contact information for your vision insurance provider is provided in the back of this Guidebook.

Please keep in mind that a claim for vision benefits is subject to specific deadlines and procedures, all of which are set forth in the carrier's benefit booklet and/or certificate of coverage.

Termination Of Coverage

Conditions Under Which Coverage Terminates

For vision coverage, you and your eligible dependents are subject to the same coverage termination provisions set forth in **Section 2, Medical Plans**.

Section 5

DXC LifeManagement Program & Other Life Services

DXC LifeManagement Program, Life Services & Other Voluntary Programs

Introduction

DXC recognizes that demands at work or home often make your life difficult and interfere with your job performance; therefore, DXC offers several programs to help you manage your personal life:

- The DXC LifeManagement Program (DXC's Employee Assistance Program (EAP))
- Torchlight Caregiver and Parent Support Services
- Bright Horizons Enhanced Family Supports program
- DXC Perks At Work
- Voluntary Programs
  - MetLife Hospital Indemnity
  - MetLife Accident Plan
  - MetLife Critical Illness Plan
  - Allstate Identity Protection
  - MetLife Legal Plan
  - Farmers Auto & Home Insurance
  - MetLife Pet Insurance

DXC LifeManagement Program

The DXC LifeManagement program can help you and your family members find solutions to the challenges you may face throughout all life stages. The DXC LifeManagement program is a confidential service that is available within the United States 24 hours a day, 365 days a year.

The LifeManagement program is administrated by Magellan Health Services.[1]

The program provides in-person assessment, guidance, professional consultation, and resources in your community that can help.

Employee and Family Eligibility

The LifeManagement Program is maintained under ERISA Plan number 502. For a list of participating employers for this ERISA Plan, see **Section 15, ERISA Information**. Section 15 shows whether a participating employer offers theLifeManagement program to its employees. Not all employers offer this coverage. Also, some participating employers only offer this coverage to certain groups of employees. See **Section 15, ERISA Information** for more information.

You are eligible for coverage in the LifeManagement program the first day you report to work if you:

- Are an employee who is on a U.S. payroll; and
- Are a regular full-time, limited-term full-time, regular part-time, limited-term part-time employee, casual, or temporary employee; and
- Are not covered under a collective bargaining agreement (CBA), unless the agreement specifically includes participation in this plan's features.

[1] Employees residing in Puerto Rico who have DXC medical coverage through Triple-S Salud or MCS, also have EAP services as part of their medical plan. These services are in addition to benefits covered in the DXC LifeManagement program administered by Magellan. See **Medical Benefits for Employees Residing in Puerto Rico**, under **Section 2**, **Medical Plans.**

If you were not at work on the date this coverage would normally become effective, you will be covered upon reporting to work on a regular full-time or part-time or limited-term full-time or part-time basis.

Coverage includes benefits for you and your household members. It also includes unmarried dependents not residingwith you, as long as they are not in military service.

The following employees are not eligible:

- Employees covered under a collective bargaining agreement (CBA), unless the agreement specifically includes participation in the EAP

Refer to the **DXC Employment Classification Policy** (available on Employee Connect) for definitions of the various employment classifications, which are also listed in **Section 1, Introduction and Eligibility**. The same provisions apply to this benefit plan.

Cost of Participation in the Program

The cost to participate in the DXC LifeManagement program is entirely company-paid, and eligible employees are automatically enrolled.

Benefits Provided

In the event of a conflict between the benefits described here and benefits described in the applicable carrier's Certificate of Coverage, the Certificate of Coverage shall control. The DXC LifeManagement program provides a wide range of services, including:

Counseling

The program provides in-person and virtual professional counseling services and resources in your community that can help you and your family members find solutions to life's challenges.

Each household member may receive up to 8 pre-paid counseling sessions (per counseling issue, per 12-month period). If additional treatment resources are necessary, the cost of such additional treatment will be subject to the copayments, deductibles, and other limitations of any healthcare plan or health maintenance organizations in which you participate. Information and resources provided through the online program may be provided to employees at no additional cost. EAP counselors can assist with issues including but not limited to:

- Adjustment to change
- Alcohol or drug dependencies (symptoms, treatment, local resources and training guides for managers)
- Depression, anxiety and stress
- Emotional well-being
- Family and parenting issues
- Grief counseling
- Marital or relationship issues
- Pre- and post-natal care
- Tobacco cessation (employees only)

Tele-Coaching

Available by phone or video conference, this service is for members who want to change or improve an aspect of their lives and could use a helping hand in creating an action plan. Members meet with the same coach until they satisfy their needs. Coaching sessions are separate from counseling and are not part of the eight-session counseling limit.

DXC LifeManagement Military

DXC LifeManagement Military provides specialized EAP coaching and individualized support for active-duty military, reserves, and veterans, as well as their dependents. DXC LifeManagement Military can help you or your dependents with matters such as deployment planning, reintegration after a deployment, as well as transition to the civilian workplace and life outside of the military. Your coach can also provide a wide variety of resources to help in areas such as finances, legal, education, access to healthcare, and more.

Work-Life Services

Work-Life Services can help you and your family members find solutions to the challenges you may face throughout all life stages. These issues can include:

- Prenatal care
- Adoption
- Childcare (including nannies, daycare services, and more)
- Elder care (including housing, care options, caregiving support, and more)
- Deployment
- School and college search
- Retirement planning
- Senior care
- Special needs services, among others.

Work-Life Tools

You have access to live and on-demand webinars, live talks, and other resources on various life event topics such as parenting issues (e.g., how to protect your child from bullying, caring for a child with special needs), managing finances and debt, time management, decluttering, and more.

LifeMart® Discounts

LifeMart® is the Magellan employee discount program. Visit LifeMart® to access hundreds of deals on nationally recognized brand-name products and services, all in one convenient location. Discounted offerings include:

- Day Care
- Hotels & Rental Cars
- Shopping
- Gym Memberships
- Home & Auto
- Dining & Entertainment
- Theme Parks
- And more!

Legal & Financial

Legal and Financial services are available to you and your family that can help with numerous types of issues, including:

- Free initial legal consultation
- Free initial financial consultation
- Discounts on continuing legal consultations

- Identity theft assistance

Contact Information

For additional information on services available through the DXC LifeManagement program, or if you need EAP counseling, call 1.888.696.4272 (1.800.456.4006 TTY/TDD). Representatives are available 24/7 to assist. You can also access the program website as follows:

- Go to www.magellanascend.com
- Select “Find My Company/Log In”
- Enter “DXC” for the company name to access the DXC program website, log in to your account, or create a new account

Registration is not required to access the DXC program website, however in order to see certain DXC program information, saving programs, and select online tools you will need to create a user account. Your information is private and confidential.

Conditions Under Which Coverage Terminates

Coverage under the DXC LifeManagement program for you and your covered family members ends on the last day of the month following the month in which your eligibility terminates because:

- Your employment with DXC ends (except see Section 6, Continuation of Coverage and COBRA)
- You no longer meet the definition of an eligible employee (except see **Section 6, COBRA Rights**)
- The program ends

Additional Conditions When Family Member Coverage Terminates

In addition to the conditions above, family member coverage ends on the earlier of the following dates:

- Your spouse is no longer an eligible family member by reason of legal separation or divorce (except see **Section 6, COBRA Rights**)
- Your child is no longer an eligible family member (except see **Section 6, COBRA Rights**)
- Upon your failure to satisfy any dependent verification requests

Continuation of Coverage

If you are eligible for the LifeManagement program at the time of termination of employment with DXC, you may be eligible to continue coverage as authorized under **Section 6, COBRA Rights**. The same provisions apply to this benefit plan.

Torchlight Caregiver and Parent Support Services

Torchlight is your partner in caregiver and parenting support. Whether you’re raising children or caring for a spouse or an elderly family member, Caregiver and Parent Support Services through Torchlight will help you get the tools and resources you need to support your unique caregiver or parenting challenges.

Torchlight Child and Torchlight Elder provides real-time, digital-first access to caregiver and parent-as-caregiver strategies to help support, offer direction, share relevant expert knowledge, and on-demand answers no matter the caregiving stage/age, situation, or concern. Requests for expert advisor calls can also be initiated through the Torchlight Child or Torchlight Elder platform. **Torchlight Caregiver and Parent Support Services is not considered a component of a DXC-sponsored ERISA plan.**

You are eligible for coverage in the Torchlight Caregiver and Parent Support Services program the first day you report to work if you:

- Are an employee who is on a U.S. payroll; and

- Are a regular full-time or a limited-term full-time; and
- Are not covered under a collective bargaining agreement (CBA), unless the agreement specifically includes participation in this plan's features.

If you were not at work on the date this coverage would normally become effective, you will be covered upon reporting to work on a regular full-time or part-time or limited-term full-time or part-time basis.

The following employees are not eligible:

- Part-time employees (regular and limited-term)
- Temporary employees
- Casual employees

Cost of Participation in the Program

The cost to participate in the Torchlight Caregiver and Parent Support program is entirely company-paid, and eligible employees are automatically enrolled.

Access Information

You can access the program platform as follows:

- Go to: https://dxc.torchlight.care/
- Select "Torchlight Child" or "Torchlight Elder" and click "Explore Now"
- The first time you access the portal, you will need to create an account by entering your first name, last name, email address, and choosing a password.

You can create an account in both the Torchlight Child and Torchlight Elder platforms. Although they are separate accounts, you may easily toggle between the platforms.

Your information is private and confidential.

Bright Horizons Enhanced Family Supports

Bright Horizons Enhanced Family Supports provides employees with resources to locate short-term and ongoing care, as well as other support for the entire family. **Bright Horizons Enhanced Family Supports is not considered a component of a DXC-sponsored ERISA plan.** Under this benefit, employees have access to a free database for finding:

- Nannies, baby sitters for evening and weekend care
- Housekeepers
- Tutors and homework help
- Camps during school breaks
- Before/After school care
- Elder care resources, planning and referrals
- Pet sitters and dog walkers.

Additional benefits include:

- Preferred enrollment access at Bright Horizons' regular full-time, center-based child care centers and over 2,500 network centers
- Access to expert senior care advisers for assistance with elder care options
- Unlimited, free basic background checks for assessing babysitters, nannies and pet sitters. You can access these services at: https://clients.brighthorizons.com/dxc.

You are eligible for Bright Horizons Additional Family Supports if you are paid on the DXC U.S. payroll. Your eligibilityto participate in this program ends when your employment terminates, or as of the date you no longer meet the definition of an eligible employee.

DXC Perks at Work

DXC Perks At Work is an employee discount program. It offers discounts that are in addition to any available through the DXC LifeManagement Plan. **DXC Perks At Work is not considered a component of a DXC-sponsored ERISAplan.** The discount program is managed by Next Jump, which designs the program and determines the offerings. A limited number of offerings are sourced exclusively by DXC for its own employees. Generally, the offers available are for shopping (e.g., clothing, electronics, automobiles) and services (travel, car rental, home & auto insurance, entertainment). Visit https://www.perksatwork.com to register.

You are eligible for DXC Perks At Work if you are paid on the DXC U.S. payroll. Your eligibility to participate in this program ends when your employment terminates, or you no longer meet the definition of an eligible employee.

Voluntary Health Protection PlansAetna Hospital Indemnity

Hospitalization insurance (also referred to as Hospital Indemnity Insurance) is a voluntary health protection plan offered through Aetna. It can help offset expenses that might not be covered under your medical plan. If you elect coverage, you will receive a cash benefit — per day, per week, per month or per visit — if you or a covered family member is confined in a hospital.

You can use the money received from Hospital Indemnity Insurance however you choose, whether for hospital bills or other costs that come up while you're recovering. This voluntary benefit is in addition to your medical coverage.

You can elect hospitalization insurance for yourself and your dependents when you are newly eligible or during Benefits Annual Enrollment. Although you do not need to be enrolled in DXC medical coverage to elect hospitalization insurance, this is not a substitute for medical insurance.

Cost of Participation in the Program

You pay the full cost of Hospital Indemnity Insurance. The cost of participating in Hospital Indemnity Insurance is available on the DXC Benefits enrollment portal when you are ready to enroll.

MetLife Accident Plan

Accident insurance is a voluntary health protection plan offered through Aetna. It provides a lump sum cash benefit if you have an accidental injury, such as a broken leg. The cash benefit is in addition to any benefit you receive from your DXC-sponsored medical and/or disability coverage, and you can spend the money in any way you'd like.

For example, you can use the money to help pay costs not covered by your medical plan, such as your medical deductible, or you can use it to pay everyday personal expenses such as transportation or childcare.

You can elect accident insurance for yourself and your dependents when you are newly eligible or during DXC's Benefits Annual Enrollment. Although you do not need to be enrolled in DXC medical coverage to elect accident insurance, this is not a substitute for medical insurance.

Cost of Participation in the Program

You pay the full cost of Accident insurance. The cost of participating in Accident insurance is available on the DXC Benefits enrollment portal when you are ready to enroll.

MetLife Critical Illness Plan

Critical illness insurance is a voluntary health protection plan provided through Aetna. It provides a lump sum cash benefit if you are diagnosed with a condition covered under the policy, such as cancer, a heart attack, stroke, or organ failure.

The cash benefit is in addition to any benefit you receive from your medical and other coverage, and you can spend the money in any way you'd like. For example, you can use the money to help pay for groceries, car payments, out-of-pocket medical costs, rehabilitation, special dietary needs or anything else you need.

You can elect critical illness insurance for yourself and your dependents when you are newly eligible or during Benefits Annual Enrollment. Although you do not need to be enrolled in DXC medical coverage to elect critical illness insurance, this is not a substitute for medical insurance.

Cost of Participation in the Program

You pay the full cost of Critical Illness insurance. The cost of participating in Critical Illness insurance is available on the DXC Benefits enrollment portal when you are ready to enroll.

Other Voluntary Benefit Options

MetLife Identity Protection

The identity theft protection benefit can protect you and your family from the cost and inconvenience of identity theft and can assist you in recovering your credit and credentials if your identity is ever stolen.

This benefit is offered by Allstate Identity Protection.

You can elect identity theft protection for yourself and your dependents when you are newly eligible or during Benefits Annual Enrollment.

Cost of Participation in the Program

You pay the full cost of Identity Theft Protection coverage. The cost of participating in Identity Theft Protection is available on the DXC Benefits enrollment portal when you are ready to enroll.

MetLife Legal Plan

The legal services benefit makes it easy to get advice or representation from an attorney on hundreds of covered legal issues, including estate planning, buying and selling property, marriage, divorce, adoptions and just about any legal concern you may have. You can also access self-serve legal documentation services and a legal resources information center.

If you use a network attorney, you don't pay any fees, deductibles or copays.

If you elect this benefit, your eligible family members can also access legal services through the plan.

This benefit is offered by MetLife Legal Plans.

You can elect the legal services benefit for yourself and your dependents when you are newly eligible or during Benefits Annual Enrollment.

Cost of Participation in the Program

You pay the full cost of the Legal Plan coverage. The cost of participating in the Legal Plan is available on the DXC Benefits enrollment portal when you are ready to enroll.

Farmers Auto & Home Insurance

DXC employees can receive discounted home, property and renter's insurance through Farmers GroupSelect℠. Depending on the policy you choose and insurance requirements in your state, you may also receive:

- Replacement cost coverage
- Referral networks
- Automated payment options
- ID protection services

You can elect coverage at any time throughout the year.

Your specific cost depends on the type and amount of coverage you choose and is based on your individual situation. If you select home insurance through this voluntary benefit, you will be directly billed by the insurance company (no payroll deductions).

To receive discounts and special offers, be sure to use the DXC discount link. You may also receive offers directly from Farmers throughout the year.

DXC employees can receive discounted auto insurance through Farmers GroupSelect℠. Options include coverage for an automobile, boat, recreational vehicle and other types of personal transportation. Depending on the policy you choose and insurance requirements specific to your state, you may also receive:

- Automated payment options
- Claim-free driving rewards
- Enhanced rental car damage coverage
- No deductible repairs for certain windshield damage
- Roadside assistance
- Guaranteed auto repairs for covered losses
- ID protection services

You can elect coverage at any time throughout the year.

Your specific cost depends on the type and amount of coverage you choose and is based on your individual situation. If you select auto insurance through this voluntary benefit, you will be directly billed by the insurance company (no payroll deductions).

To receive discounts and special offers, be sure to use the DXC discount link, which can be found at mydxcbenefits.com.

Cost of Participation in the Program

This is a discount arrangement only. You pay the full cost of your Home and/or Auto coverage directly to MetLife.

MetLife Pet Insurance

You have an opportunity to insure your eligible pets — cats, dogs and some exotic animals depending on your state — with the pet insurance benefit offered by MetLife.

This benefit provides:

- A 10% group discount plus additional multi-pet and military/first-responder/healthcare discounts.
- Flexible product offerings with straightforward pricing and options, group discounts, customizable limits and deductible savings
- An experienced team of pet advocates and a variety of support options
- An easy claims experience with most claims processed within 10 days

Request a quote and elect coverage at our discount link, which can be found at mydxcbenefits.com, or call 1-800-GET-MET8.

If you choose this option, payments are made directly to MetLife. MetLife Pet Insurance is not available for our employees in Puerto Rico.

Cost of Participation in the Program

This is a discount arrangement only. You pay the full cost of your Pet Insurance directly to MetLife.

Section 6

COBRA Rights

COBRA Rights

Introduction, Eligibility, & Enrollment

There are certain circumstances that will allow you and your eligible dependents to continue coverage beyond the date that your coverage would normally terminate. The provisions for continuation of coverage are dictated by the Consolidated Omnibus Budget Reconciliation Act (COBRA). This section is intended to inform you, in a summary fashion, of the events that allow continuation of coverage, and the responsibility you and the company have to ensure such continuation. It is important that you and your spouse (if applicable) take the time to read and understand these rights. The following benefits are eligible for continuation under COBRA:

- Medical
- Dental
- Vision
- DXC LifeManagement Program
- Health Flexible Spending Account
- Health Reimbursement Arrangement

The DXC COBRA program is administered by the DXC Benefits Center managed by Businessolver.

Employee & Dependent Eligibility

To be eligible for benefits coverage under COBRA, you must:

- Be covered by a DXC medical/prescription drug plan, dental plan, vision plan, LifeManagement, and/or the DXC Health Flexible Spending Plan (FSA), at the time of a COBRA qualifying event (as set forth in the chart below); and
- Experience a COBRA qualifying event that results in loss or termination of plan coverage.

If the above requirements are met, DXC will offer eligible individuals the option to continue these coverages on a post-tax basis for specific periods of time.

COBRA prescribes the following as qualifying events:

#	COBRA Qualifying Events	Eligible Individuals (Qualified Beneficiaries)	Maximum Period of ContinuedCoverage
1	Termination of employment for any reason, except gross misconduct	Employee and family members covered on date of termination	18 months
2	Reduction in work hours resulting in a loss or reduction of benefits (e.g., to fewer than 30 hours per week)	Employee and family members covered on the date benefits terminate	18 months
3	Employee‘s death	Family members covered on the date of death	36 months
4	Divorce or legal separation[1]	Spouse covered on the date of the event (eligible dependent	36 months

		children may continue to be covered)	
5	Dependent children become ineligible under the terms of the plan	Dependent children covered on the date of the event	36 months
6	Employee becomes entitled to Medicare and, as a result, loses coverage[2]	Family members covered on the date of the event	36 months from the earlier of date of termination or Medicare entitlement
7	Secondary events or combination of events	Individuals covered on the date of the initial qualifying event	Up to 36 months — all events combined

1. A "legal separation" is a separation pursuant to a court order that defines legally enforceable rights and obligations of the parties. Merely living apart is not a legal separation.
2. Note that under current DXC medical plan eligibility rules, employees do not lose eligibility for DXC medical coverage when they become entitled to Medicare, so this event would not arise.

Maximum Period of Continued Coverage: This is the maximum duration that an eligible person can continue coverage under COBRA, and runs from the date of the COBRA event. It includes any period during which DXC pays the cost of the elected COBRA coverage (e.g., death of employee, layoff). **The eligible individual(s) must enroll in COBRA continuation coverage within the required time period to be eligible for any DXC-paid continuation coverage (subsidy).**

Flexible Spending Accounts: If, at the time of termination, you have an unused balance in your Healthcare FSA account, you may elect to continue participation in your Healthcare FSA only until the end of the plan year in which the termination occurs.

COBRA Rules for Specific Events

Disability Extension and COBRA

The maximum period of coverage for qualifying events 1 and 2 may be extended up to 29 months if you or a covered family member is certified totally disabled by the Social Security Administration (SSA) prior to the qualifying event, or within the first 60 days of COBRA continuation coverage. Under this provision, each qualified beneficiary (regardless of whether disabled) may extend COBRA continuation for up to an additional 11 months. To qualify for this disability extension, it is your responsibility to provide the COBRA administrator a copy of the Social Security Notice of Award within 60 days of the issuance of the SSA determination, and before the end of the original 18-month COBRA continuation period.

The cost of coverage during the disability extension period will increase to 150% of the cost of coverage plus administrative fees if the disabled person is one of the individuals electing extended coverage.

If SSA determines that you or your covered family member is no longer disabled, you are required to notify the COBRA administrator within 30 days of this determination.

New Child and COBRA

If you have a new child during the COBRA continuation period, your new child is eligible to be enrolled within 30 days of the birth, adoption, or the date you become legally obligated to provide support for the child. You will not have to wait until the next Benefits Annual Enrollment period to enroll your new child.

Marriage and COBRA

If you marry during the COBRA continuation period, your new spouse is eligible to be enrolled within 30 days of the date you become legally married. You will not have to wait until the next Benefits Annual Enrollment period to enroll your new spouse.

Layoff

If termination of coverage results from layoff, and you are eligible for a DXC COBRA 30-day subsidy for medical coverage continuation, you and/or your enrolled dependents **must enroll in COBRA medical coverage by notifying the COBRA administrator, see Electing and Paying for COBRA Continuation Coverage below, in order to receive this subsidy**. In addition, if you elect to keep other coverages (e.g., vision, dental, employee assistance program), you are responsible for making timely payment of the required premiums for these other coverages before your 30-day medical coverage subsidy becomes effective.

NOTE: If you elect to enroll in medical, dental, and/or vision, but do not submit required payment in a timely manner, only the medical coverage will be effective for 30 days. When COBRA is terminated, there is no reinstatement.

Death

When termination of coverage results from your death while covered by this plan as an active employee, and your eligible family members were covered under the plan immediately prior to your death, DXC will pay for up to the first six months of continuation coverage for medical benefits under COBRA. However, if you are enrolled in a healthcare FSA, the FSA is not covered under this six-month subsidy period. Eligible family members **must enroll in COBRA medical coverage by notifying the COBRA administrator within the required time period**, see **Electing and Paying for COBRA Continuation Coverage** below, for it to be effective. At the end of this six-month period, your covered family members may elect to continue this coverage for an additional 30 months. If coverage is continued, eligible family members must pay the entire cost of such coverage plus an administrative fee (see **COBRA Cost**, below).

Leave of Absence

Refer to Section 14, **DXC Technology Company Cafeteria Program, Continuation of Coverage** and also to the **DXC U.S. Leaves with Pay Policy**, and **DXC U.S. Leaves without Pay Policy** for information on impact of a leave of absence on benefit eligibility. These policies can be found on Employee Connect, which can be accessed through the DXC Intranet.

Giving Notice That a COBRA Qualifying Event Has Occurred

The way in which DXC'S COBRA administrator will need to be notified depends on the COBRA qualifying event from the above table that triggered eligibility:

Qualifying Events 1, 2, and 3: The DXC Benefits Center, DXC's COBRA administrator, will initiate action when events 1, 2, or 3 occur. In the event of your death, the DXC Benefits Center will provide COBRA information to your covered dependents.

Qualifying Events 4, and 5: To qualify for COBRA continuation coverage upon divorce, legal separation, or dependent child becoming ineligible (i.e., if events 4 or 5 occur), you or your covered family member(s) are responsible for notifying the DXC Benefits Center within 60 days of the event, by:

- Calling 1.888.305.5499;
- Logging on to the DXC Benefits Center portal (myDXCbenefitscenter.com); or
- Sending a written notice to the DXC Benefits Center.

Qualifying Event 6: If an active employee becomes entitled to (i.e., enrolled in) Medicare, and the plan terminates coverage for a covered/enrolled dependent spouse (such that a COBRA qualifying event occurs), then COBRA provides that continuation of coverage may extend for up to 36 months for **dependents only if the employee was on Medicare within 18 months of the qualifying event that led to COBRA**. The employee would need to provide proof of the date s/he enrolled in Medicare.

However, event 6 as a qualifying COBRA event **is unlikely to occur under the DXC plans** since coverage for DXC active employees (and their dependents) does not terminate because of an employee's entitlement to Medicare.

Qualifying Event 7: Should a second qualifying event occur while you or your covered family members are already covered by COBRA continuation coverage due to an earlier qualifying event, you or your covered family members must notify the DXC Benefits Center, DXC's COBRA administrator, within 60 days of the second event. This notification will protect any additional rights that may be available.

You must notify the DXC Benefits Center of your intent to continue coverage, within 60 days of a qualifying event, so that your right to continue coverage is assured. Shortly after the DXC Benefits Center becomes aware of a qualifying event, the DXC Benefits Center will provide you and/or your eligible family members with complete details regarding the right to continue coverage.

Electing and Paying for COBRA Continuation Coverage

You will have 60 days from the date of your COBRA notification outlining your options to make your decision and notify the COBRA administrator in writing, on the prescribed form, of your election to continue or decline continued coverage. If you do not return the form within 60 days, benefits will terminate on the date of the qualifying event and you will forfeit your right to COBRA continuation coverage. No further action will be taken.

If you elect COBRA continuation coverage, you must pay the initial premium (including all premium payments due retroactive to the COBRA eligibility date) within 45 days after your election. If you make the required payment by the due date, coverage will be retroactive to the first day you became eligible. Thereafter, COBRA premiums must be paid within 30 days of each monthly due date. Coverage will not be updated with the carriers until required payment(s) are received and processed.

If you do not make the required full initial premium payment and subsequent monthly payments by the due date, you will forfeit your rights to COBRA continuation coverage. Once your COBRA continuation coverage is terminated, it cannot be reinstated.

Coverage offered through COBRA continuation coverage will be the same coverage that is offered to active employees. Any changes made to the active plan will apply to participants under COBRA. Evidence of insurability will not be required. Individuals who elect to continue coverage will be responsible for the full cost of the plan plus 2% for administrative expenses, as permitted by law.

COBRA Cost

Eligible persons will pay the full premium or premium equivalent plus a 2% administration fee for each benefit continued under COBRA.

Coordinating COBRA with Other Coverage

COBRA coverage is secondary to any non-active coverage (e.g., Medicare, retiree medical). If you are eligible for Medicare, the plan will assume you have enrolled in both Part A and Part B, regardless of whether you have actually enrolled.

When COBRA Continuation Coverage Ends

If elected, COBRA continuation coverage ends the earliest of:

- The date the covered individual fails to pay the COBRA premium as required
- The date the individual who elected continued coverage first becomes covered, after electing COBRA, under another group health plan (e.g., another employer-provided plan, Medicare), unless the

individual has a pre-existing condition that is excluded from coverage under the other group health plan

- The date DXC ends the plan under which coverage is provided. If coverage is replaced, the individual may elect to continue coverage under the new plan.
- The date which is:
  - 18 months from the date of the qualifying event (or 29* months if a covered individual is certified totally disabled by the Social Security Administration) if the qualifying event was 1 or 2 (see **Qualifying Events Chart**), or
  - 36 months from the date of the qualifying event for all other qualifying events. A maximum period of 36 months from the date of the initial qualifying event applies to any combination of events.

*In the event that a covered individual is determined by Social Security Administration (SSA) to no longer be disabled, their coverage will end the earlier of the date they are no longer disabled (per SSA) or the end of the 29-month period.

In compliance with COBRA, spouses of employees must also be notified of the availability of continued coverage. If applicable, please share the information in this Section 6 with your spouse. If you have changed marital status or you or your spouse have changed addresses, please contact the DXC Benefits Center, DXC's COBRA administrator. If you have questions about COBRA, please contact the DXC Benefit Center at 1.888.305.5499.

COBRA Administration

All coverages continued under COBRA are administered by the DXC Benefits Center managed by Businessolver. COBRA administrative services include all notifications, maintenance of eligibility lists, changes in eligibility, etc.

Contacting the Administrator

Contact information for all benefit carriers and administrators is provided in the back of this Guidebook.

Conversion Privileges

There is no conversion privilege under the plans subject to COBRA (listed above).

Section 7

Life Insurance Plans

Life Insurance Plans

Introduction

DXC offers the following life insurance benefits to you and your dependents:

- Basic Employee Life Insurance for the Employee (Basic Employee Life)
- Supplemental Life Insurance for the Employee, Spouse/Domestic Partner, and/or Dependent Children (Employee Supplemental Life, Spouse Supplemental Life, and Child Supplemental Life)

These benefits are insured and administered by Metropolitan Life Insurance Company (Metlife or the Insurer).

For purposes of these coverage options, base annual earnings (BAE) means your annual base compensation, rounded to the next higher $1,000 increment, if not already an even multiple of $1,000 (excluding overtime, shift differential, bonuses, living or other allowances).

If your compensation is subject to a formal sales incentive plan at the beginning of the payroll year, your premium and benefits will be calculated at the beginning of that payroll year and remain unchanged for the payroll year (as long as you continue to be an eligible enrolled employee). The calculation will include your usual base rate of pay on the last day of the prior payroll year, plus paid draws and any paid formal sales incentive amounts that exceed the draw amounts paid in the preceding payroll year.

Any change in the amount of coverage due to a change in compensation will not take effect unless and until an employee is at work.

Employee Life Insurance (Basic and Supplemental)

Introduction

DXC automatically provides Basic Employee Life coverage for all eligible employees, at no cost to the employee (unless the coverage is over $50,000, in which case the employee will have imputed income for tax purposes). DXC also offers optional employee-paid Employee Supplemental Life coverage options.

For convenient reference in this Guidebook, life insurance coverage is described as a separate plan. These benefits are provided as a sub-part of the ERISA plan through which other fully insured benefits are provided (such as Spouse Supplemental Life and disability coverages). That ERISA plan is number 502.

For a list of participating employers for the overall ERISA Plan of which this coverage is a part, see **Section 15, ERISA Information**. Section 15 also shows whether a participating employer is offering the Employee Life Insurance Plan to its employees. Not all employers offer this coverage. Also, some participating employers only offer this coverage to certain employee groups. See **Section 15, ERISA Information** for more information.

Employee Eligibility

For life insurance coverage, you are subject to the same provisions and definitions regarding eligibility as set forth in **Section 2, Medical Plans.**

If you elect employee coverage, you may also elect to cover your eligible family members under the same plan.

Enrollment/Effective Date of Coverage

Basic Employee Life Insurance

Participation in Basic Employee Life coverage is automatic and does not require enrollment. Coverage is effective on the date you are first eligible for this coverage.

Enrolling in Employee Supplemental Life Coverage

Employee Supplemental Life coverage is an optional plan for eligible employees and requires enrollment. You can enroll yourself in Supplemental Life coverage at one of the following times:

1. Within 30 days of your hire date (or initial date of eligibility) or by the deadline on your enrollment notice (whichever is later); or
2. During the Annual Benefits Open Enrollment period; or
3. Within 30 days of a qualified change of status, special enrollment, or a specifically permitted event (all as described in **Section 14, DXC Technology Company Cafeteria Program** under **Changing Your Cafeteria Plan Elections)**.

To enroll yourself you must complete your enrollment by accessing the DXC Benefits Center online (myDXCbenefitscenter.com) or calling at 1.888.305.5499.

Evidence of Insurability (EOI) is required for some levels of coverage. See **Evidence of Insurability**, later in this section.

The consequences for not enrolling in Employee Supplemental Life are as follows:

- If you do not enroll within one of the periods described above, your Employee Supplemental Life election will default to waiver of coverage.
- If the annual enrollment period requires active enrollment for the following plan year, and you do not enroll, your Employee Supplemental Life election will default to waiver of coverage.

It is your responsibility to review your remuneration statement (paystub) to confirm deductions accurately reflect your elections.

Your election is irrevocable and binding. Your next opportunity to enroll or make enrollment changes will be during the Annual Benefits Open Enrollment period, unless you have a qualified change of status, are eligible for a special enrollment or have another specifically permitted event as described in **Section 14, DXC Technology Company Cafeteria Program** under **Changing Your Cafeteria Plan Elections**. The same provisions also apply to this benefit plan.

Effective Date of Employee Supplemental Life Coverage

Coverage Level	Enrollment Event	Effective Date
1, 2, or 3 times Basic Employee Life amount	New Hire/Newly Eligible	Retroactive to hire date/initial date of eligibility
1, 2, or 3 times Basic Employee Life amount[1]	Annual Benefits Open Enrollment	January 1 of new plan year or retroactive to date Insurer approves EOI – whichever is later
1, 2, or 3 times Basic Employee Life amount[1]	Qualified change of status, special enrollment or specifically permitted event	Retroactive to date Insurer approves EOI

4 or 5 times Basic Employee Life amount[1]	New Hire/Newly Eligible	3x will be effective immediately; additional levels will be effective retroactive to date insurer approves EOI
4 or 5 times Basic Employee Life amount[1]	Annual Benefits Open Enrollment	January 1 of new plan year or retroactive to date Insurer approves EOI – whichever is later
4 or 5 times Basic Employee Life amount[1]	Qualified change of status, special enrollment or specifically permitted event	Retroactive to date Insurer approves EOI

1. Evidence of Insurability is required for this enrollment event and coverage level

Deferred Effective Date Provision

The effective dates above are subject to the Deferred Effective Date Provision. If you are absent from work due to sickness or injury on the date coverage or an increase in coverage would have otherwise been effective, the effective date of coverage will be deferred until you have returned to active work for one full work day.

Evidence of Insurability

Evidence of Insurability (EOI) is required for certain levels of coverage and/or enrollment events. Enrollments or increases to Employee Supplemental Life coverage will not be effective unless and until the Insurer approves your EOI statement. *For coverage that requires EOI, the Insurer may still deny coverage after receipt and review of the required documentation.* EOI may include, but is not limited to:

- Completed, signed application
- Medical exam
- Attending physician statement
- Any other information the Insurer may require

EOI and Employee Basic Employee Life Insurance

EOI is not required for Basic Employee Life coverage.

EOI and Employee Supplemental Life Insurance

EOI requirements for Employee Supplemental Life are shown in the following table:

Coverage Level Elected	Enrollment Event[1]	EOI Required?
1, 2, or 3 times Basic Employee Life amount[2]	New Hire/ Newly Eligible	No
1, 2, or 3 times Basic Employee Life amount	Annual Benefits Open Enrollment	Yes
1, 2, or 3 times Basic Employee Life amount	Qualified change of status, special enrollment or specifically permitted event	Yes
4 or 5 times Basic Employee Life amount	New Hire/ Newly Eligible	Yes
4 or 5 times Basic Employee Life amount	Annual Benefits Open Enrollment	Yes
4 or 5 times Basic Employee Life amount	Qualified change of status, special enrollment or specifically permitted event	Yes

1. Includes increases in coverage
2. See *Basic Employee Life Coverage Amount* section below

EOI requirements apply only to changes in coverage level (i.e., multiples of Basic Employee Life coverage amount), not to changes in coverage related to salary increases.

Elections requiring EOI will not be effective unless the Insurer approves your application (see **Annual Benefits Open Enrollment Period/Changing Your Elections)**. See above under **Effective Date of Employee Supplemental Life Coverage** for when coverage elections requiring EOI are effective.

How to Submit EOI

When you enroll in the DXC Benefits Center enrollment portal (myDXCbenefitscenter.com) for coverage requiring EOI, a link to the Insurer's EOI processing website will appear in the enrollment workflow. Please follow the link for instructions on submitting EOI.

Annual Benefits Open Enrollment/Changing Your Elections

Annual Benefits Open Enrollment Period

Once each year, you have an opportunity to change your Employee Supplemental Life elections. The Annual Benefits Open Enrollment (Annual Enrollment) period is usually held in October/November for an effective date of January 1 of the new plan year. See **EOI and Employee Supplemental Life Insurance**, above, for changes requiring EOI. See also **Effective Date of Supplemental Life Coverage,** above, for when coverage elections requiring EOI are effective.

The elections you make during the Annual Enrollment period, including default elections, are irrevocable and binding until the next Annual Enrollment period, unless you are eligible to change your elections as described in **Section 14**, under **Changing Your Cafeteria Plan Elections**. The same provisions also apply to this benefit plan.

Unless the company communicates otherwise prior to Annual Enrollment, your Employee Supplemental Life coverage will continue each year as previously elected, but at new plan year prices, unless you make a change during the Annual Enrollment period. This must not be interpreted as a promise or guarantee that the same benefit plans will be available to you from one year to the next. (See **Introduction** on **page 7-1**, above.)

Also see Section 14, **DXC Technology Company Cafeteria Program, Annual Enrollment**. The same provisions also apply to this benefit plan.

Changing Your Elections

See **Section 14, DXC Technology Company Cafeteria Program under Changing Your Cafeteria Plan Elections**. The same provisions also apply to this benefit plan.

Cost of Employee Participation in Life Insurance Coverage

Cost of Basic Employee Life

DXC pays 100% of the cost to provide eligible employees with Basic Employee Life coverage.

Cost of Employee Supplemental Life

You pay the full cost of Supplemental Life coverage. The cost of participating in Supplemental Life is available on the DXC Benefits enrollment portal when you are ready to enroll.

Pre-Tax Contribution for Supplemental Life Coverage

Your contributions for your elected Employee Supplemental Life coverage will be taken from your gross salary through payroll deductions before federal income taxes are calculated and before state income taxes are calculated (in states where legally permitted). Your pre-tax contributions are governed by and pursuant to the **Pre-Tax Contribution Plan**, which is a component plan of the **DXC Technology Company Cafeteria Program** described in **Section 14**.

Imputed Income

Each calendar year, the compensation on your Internal Revenue Service (IRS) Form W-2 will include the cost of group term life insurance, if any, in excess of $50,000 of coverage (this includes both basic and supplemental amounts). This is called imputed income. This imputed income is based on tables provided by the IRS and does not necessarily reflect the actual cost of the benefits.

Benefits Provided

A summary of key terms is provided below. In the event of a conflict between the benefits described here, and benefits described in the applicable carrier's Certificate of Coverage, the Certificate of Coverage shall control.

Basic Employee Life Coverage Amount (Company-Paid)

DXC provides Basic Employee Life coverage to eligible employees either in an amount equal to 100% of base annual earnings (BAE) and subject to minimum and maximum life insurance coverage provisions, discussed below, or in an amount up to $50,000 of life insurance coverage, which will not subject the employee to imputed income.

Employee Supplemental Life Coverage (Employee-Paid)

In addition to your Basic Employee Life coverage, you may elect Employee Supplemental Life coverage. The amount of your Employee Supplemental Life coverage may be equal to one, two, three, four, or five times your BAE, see **page 7-1**, subject to minimum and maximum life insurance coverage provisions, below.

Basic Employee Life and Employee Supplemental Life benefits subject to SCA/Individual Wage Determinations and for employees covered by collective bargaining agreements (CBAs) may vary.

Minimum and Maximum Life Insurance Coverage

The following coverage limits apply to Basic Employee Life and Employee Supplemental Life coverage:

- Basic Employee Life coverage has a minimum value of $10,000;
- Employee Supplemental Life coverage has a minimum value of $10,000; and
- Basic Employee Life and Employee Supplemental Life coverages combined may not exceed $1,000,000.

Benefit Reductions

Your Basic Employee Life coverage will be reduced in accordance with the table below on the date you attain the age indicated. These reductions also apply if you become covered or your coverage increases on or after the date you attain age 70.

Age	Amount by which Original Benefit is Reduced
70	35%

75	55%
80	70%

Any reductions in coverage amount because of age take place on your birthday and a premium adjustment will be made.

You may be eligible to continue the reduced coverage through the **Coverage Continuation Provision**, **Life Insurance Portability Provision** and/or the **Life Insurance Conversion Privilege** as described below.

Exclusions

The plan will not pay an Employee Supplemental Life insurance benefit if:

- You die by suicide, while sane or insane, or from an intentionally self-inflicted injury, within two years from the effective date of your coverage; or
- You die by suicide, while sane or insane, or from an intentionally self-inflicted injury, within two years from the date of an increase in your coverage.

If your death by suicide occurs more than two years after the effective date of your coverage, but within two years of the date that any increase in coverage becomes effective, no death benefit will be payable for any such increased amount.

Payment of Employee Life Insurance Benefits

Life insurance benefits will be paid to your designated beneficiary or estate, pursuant to Plan procedures, in the event of your death from any cause. Payments will be made in one lump sum payment.

Beneficiary

Election of Beneficiary(ies)

You are responsible for selecting your beneficiary for benefits under the Employee Life Insurance Plan. You may elect or change your beneficiary on the DXC Benefits Center portal at myDXCbenefitscenter.com.

Payment of Benefits to Beneficiaries

Unless you have requested something different, payment will be made as follows:

1. If more than one beneficiary is named, each will be paid an equal share, or as designated by you on your beneficiary form.
2. If any named beneficiary dies before you, his/her share will be divided equally among the named surviving beneficiaries.

Payment Where No Beneficiary Is Named or No Beneficiary Survives You

If there is no beneficiary designated, or no surviving designated beneficiary at your death, the Insurer, may determine the beneficiary to be one or more of the following who survive you:

a. All to your surviving spouse; or
b. If your spouse does not survive you, in equal shares to your surviving children; or
c. If no child survives you, in equal share to your surviving parents; or
d. If no parent survives you, in equal share to your surviving siblings.

Instead of making payment to any of the above, none of the individuals listed above are available for payment, the Insurer may pay your estate. Any payment made in good faith will discharge the Insurer's

liability to the extent of such payment. If a beneficiary or a payee is a minor or incompetent to receive payment, the Insurer will pay that person's guardian.

Termination of Employee Life Insurance Coverage

Your Basic Employee Life coverage under this plan ends on the earliest of the following dates that:

- You terminate employment with DXC;
- You no longer meet the definition of eligible employee; or
- The plan ends.

Your Employee Supplemental Life coverage under this plan ends on the earliest of the following dates that:

- You stop making required contributions in accordance with plan provisions (See **the DXC U.S. Leaves of Absence with Pay** and **DXC U.S. Leaves of Absence without Pay** policies for premium continuation requirements while on a leave of absence);
- You terminate employment with DXC;
- You no longer meet the definition of eligible employee; or
- The plan ends.

See also **Section 14, DXC Technology Company Cafeteria Program, Period of Coverage**. The same provisions also apply to this benefit plan. Benefits may be payable if your death occurs within 31 days of the date of termination of coverage. For details, see below under **Life Insurance Conversion Privilege.** You may be eligible to continue coverage through the **Coverage Continuation Provision**, **Life Insurance Portability Provision** and/or the **Life Insurance Conversion Privilege,** as described below.

Supplemental Life Insurance for Spouse/Domestic Partner & Dependent Children

Introduction

DXC offers supplemental life insurance coverage for spouses (including domestic partners) and eligible dependent child(ren) to all eligible employees as an optional employee-paid benefit. Contributions are made with post-tax dollars.

For convenient reference in this Guidebook, the supplemental life insurance coverage for spouses, including domestic partners (Spouse Supplemental Life) and dependent children (Child Supplemental Life) is described as a separate plan. These benefits are provided through a sub-part of the same ERISA benefit plan through which other fully-insured benefits are provided (such as Employee Supplemental Life and disability coverages). That ERISA plan number is 502.

For a list of participating employers for the overall ERISA plan of which this coverage is a part, see **Section 15, ERISA Information**. **Section 15** also shows whether a participating employer is offering the Employee Supplemental Life and/or Spouse/Child Supplemental Life coverage options to its employees. Not all employers offer this coverage. Also, some participating employers only offer this coverage to certain employee groups. See **Section 15, ERISA Information** for more information.

Eligibility for Spouse/Child Supplemental Life Insurance

You must be enrolled in Basic Employee Life coverage to be eligible to enroll family members in Spouse and/or Child Supplemental Life coverage.

For Spouse/Child Supplemental Life coverage, you and your dependents are subject to the same provisions and definitions regarding eligibility as set forth in **Section 2, Medical Plans.**

Verification of Eligibility for Family Coverage

For Spouse/Child Supplemental Life coverage, family members are subject to the same eligibility verification standards set forth in **Section 2, Medical Plans.**

Excluded Family Members

The following limitations apply to covering dependents under Spouse/Child Supplemental Life coverage:

- You cannot cover anyone who is covered as an employee under the policy (e.g., if your spouse or child is also a DXC employee covered by Basic Employee Life, you cannot cover him/her under Spouse/Child Supplemental Life coverage);
- No person can be insured as a dependent of more than one employee under the policy (i.e., if both you and your spouse work for DXC and want to cover your child under Spouse/Child Supplemental Life, only one of you can do so); and
- No person can be covered under Spouse/Child Supplemental Life who is on active duty in the military of any country or international authority (active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard).

You are responsible for ensuring that you are not covering an ineligible family member. And it is your responsibility to report to DXC any covered spouse or child who no longer meets the definition of an eligible family member for Spouse/Child Supplemental Life coverage. Failure to report a spouse or child as no longer eligible will result in a denial of claim payments, even if premiums were paid. You can report such eligibility changes by accessing the DXC Benefits Center portal myDXCbenefitscenter.com or by

calling (1.888.305.5499) and initiating a qualified change of status event, see **Section 14, DXC Technology Company Cafeteria Program** under **Changing Your Cafeteria Plan Elections**.

Enrollment/Effective Date of Spouse/Child Supplemental Life Coverage

Enrolling in Spouse/Child Supplemental Life Coverage

You can enroll in Spouse/Child Supplemental Life coverage at one of the following times:

1. Within 30 days of your hire date (or initial date of eligibility) or by the deadline on your new hire enrollment notice (whichever is later); or
2. During the Annual Benefits Open Enrollment period; or
3. Within 30 days of a qualified change of status, special enrollment, or a specifically permitted event (all as described in **Section 14, DXC Technology Company Cafeteria Program** under **Changing Your Cafeteria Plan Elections).**

To enroll, you must complete your enrollment online by accessing the DXC Benefits Center portal (myDXCbenefitscenter.com) or by phone 1.888.305.5499.

Evidence of Insurability (EOI) may be required. See **Evidence of Insurability**, later in this section.

The consequences for not enrolling in Spouse/Child Supplemental Life are as follows:

- If you do not enroll within one of the periods described above, your Spouse/Child Supplemental Life election will default to waiver of coverage.
- If the annual enrollment period requires active enrollment for the following plan year, and you do not enroll, your Spouse/Child Supplemental Life election will default to waiver of coverage.

It is your responsibility to review your remuneration statement (paystub) to confirm deductions accurately reflect your elections.

Your election is irrevocable and binding. Your next opportunity to enroll or make enrollment changes will be during the Annual Benefits Open Enrollment period, unless you have a qualified change of status, are eligible for a special enrollment or have another specifically permitted event as described in **Section 14, DXC Technology Company Cafeteria Program** under **Changing Your Cafeteria Plan Elections**. The same provisions also apply to this benefit plan.

Effective Date of Spouse/Child Supplemental Life Coverage

Coverage Level Elected	Enrollment Event	Effective Date
Spouse / Domestic Partner	New hire/newly eligible	Retroactive to date of initial eligibility
Spouse / Domestic Partner [1]	Annual Benefits Open Enrollment	January 1 of new plan year or retroactive to date Insurer approves EOI – whichever is later
Spouse / Domestic Partner [1]	Qualified change of status, special enrollment, or specifically permitted event (other than marriage)	Retroactive to date Insurer approves EOI
Spouse / Domestic Partner	Marriage	Date of event
Child	New hire/newly eligible	Retroactive to date of initial eligibility

Coverage Level Elected	Enrollment Event	Effective Date
Child	Annual Benefits Open Enrollment	January 1 of new plan year
Child	Qualified change of status, special enrollment, or specifically permitted event	Date of event

1. Evidence of Insurability is required for this enrollment event and coverage level

NOTE: In no event will Spouse/Child Supplemental Life coverage become effective before the date your Basic Employee Life coverage becomes effective. All effective dates of coverage are subject to the "deferred effective date provision" for dependents.

Deferred Effective Date Provision for Dependents

Spouse/Child Supplemental Life coverage will be deferred, if upon the date it is to become effective, the covered person is:

- Hospitalized
- Receiving or applying to receive disability benefits from any source
- Confined at home under a physician's care

Coverage will be effective once none of the above situations are applicable

The deferred effective date provision will not apply to disabled children who qualify under the definition of eligible dependent children.

Evidence of Insurability (EOI)

EOI is required for certain enrollment events. Enrollments or increases to Spouse/Child Supplemental Life coverage will not be effective until the Insurer approves your EOI statement. For coverage that requires EOI, the Insurer may still deny coverage after receipt and review of the required documentation. EOI may include, but is not limited to:

- Completed, signed application,
- Medical exam,
- Attending physician statement, or
- Any other information the Insurer may require.

EOI and Spouse/Child Supplemental Life Insurance

EOI requirements for Spouse/Child Supplemental Life are shown in the following table:

Coverage Level Elected	Enrollment Event[1]	EOI Required?
Spouse / Domestic Partner	New hire/newly eligible	No
Spouse / Domestic Partner	Annual Benefits Open Enrollment	Yes
Spouse / Domestic Partner	Qualified change of status, special enrollment, or specifically permitted event (other than marriage)	Yes
Spouse / Domestic Partner	Marriage	No
Child	New hire/newly eligible	No[2]
Child	Annual Benefits Open Enrollment	No[2]

Coverage Level Elected	Enrollment Event[1]	EOI Required?
Child	Qualified change of status, special enrollment, or specifically permitted event	No[2]

1. Includes increases in coverage
2. For coverage levels of $25,000 or less (current maximum benefit under this plan)

Elections requiring EOI will not be effective unless the Insurer approves your application (see **Annual Benefits Open Enrollment Period/Changing Your Spouse/Child Supplemental Life Elections)**. See above under **Effective Date of Spouse/Child Supplemental Life Coverage** for when coverage elections requiring EOI are effective.

How to Submit EOI

When you enroll in the DXC Benefits Center enrollment portal (myDXCbenefitscenter.com) for coverage requiring EOI, a link to the Insurer's EOI processing website will appear in the enrollment workflow. Please follow the link for instructions on submitting EOI.

Annual Benefits Open Enrollment/Changing Your Spouse/Child Supplemental Life Elections

Annual Benefits Open Enrollment Period

Once each year, you have an opportunity to change your Spouse/Child Supplemental Life coverage elections. The Benefits Annual Enrollment period is usually held in October/November for an effective date of January 1 of the new plan year. See above under **EOI and Spouse/Child Supplemental Life Insurance** for changes requiring EOI. See also **Effective Date of Spouse/Child Supplemental Life Coverage**, above, for when coverage elections requiring EOI are effective.

The elections you make during the Benefits Annual Enrollment period, including default elections, are irrevocable and binding until the next Annual Enrollment period unless you are eligible to change your elections as described in **Section 14**, under **Changing Your Cafeteria Plan Elections**. The same provisions also apply to this benefit plan.

Unless the company communicates otherwise prior to Annual Enrollment, your Spouse/Child Supplemental Life coverage elections will continue automatically each year as previously elected, but at new plan year prices, unless you make a change during the Benefits Annual Enrollment period. This must not be interpreted as a promise or guarantee that the same benefit plans will be available to you from one year to the next. (See **Introduction** on **page 7-1**, above.)

Changing Your Elections

See **Section 14, DXC Technology Company Cafeteria Program under Changing Your Cafeteria Plan Elections**. The same provisions also apply to this benefit plan.

Cost of Participation in the Plan

Spouse/Child Supplemental Life coverage is offered as an optional, employee-paid benefit. The cost is available on the DXC Benefits enrollment portal when you are ready to enroll in benefits. Contributions under collective bargaining agreements (CBAs) may vary. See your CBA for details, if applicable. Your contributions for your elected Spouse/Child Supplemental Life coverage will be taken from your post-tax salary through payroll deductions.

Spouse/Child Supplemental Life Benefits Provided

A summary of key terms is provided below. In the event of a conflict between the benefits described here, and benefits described in the applicable carrier's Certificate of Coverage, the Certificate of Coverage shall control. Different levels of coverage are available for Spouse/Child Supplemental Life.

Spouse / Domestic Partner

You can elect life insurance coverage for your spouse or domestic partner in the following amounts:

Spouse Life Coverage Amount
$5,000
$10,000
$25,000
$50,000
$75,000
$100,000

The amount of spousal coverage may never exceed more than 100% of the combined Basic and Supplemental insurance in which the employee is enrolled.

Eligible Dependent Child

You can elect life insurance coverage for your eligible dependent children in the following amounts:

Child Life Coverage Amount
$5,000
$10,000
$15,000
$20,000
$25,000

All eligible dependent children are covered for the same amount elected; however, you do need to indicate coverage for each individual child. You pay one flat biweekly deduction amount no matter how many children you are covering.

Maximum Spouse/Child Supplemental Life Coverage & Benefit Reduction

Spouse/Child Supplemental Life coverage cannot exceed 100% of your combined Basic Employee Life and Employee Supplemental Life coverage amount. If your Spouse/Child Supplemental Life coverage exceeds 100% of the amount in force for you – both Basic Employee Life and Employee Supplemental Life – your Spouse/Child Supplemental Life coverage will be reduced to the amount in force for you.

Exclusions

The plan will not pay a Spouse/Child Supplemental Life insurance benefit if:

- Your dependent dies by suicide, while sane or insane, or from an intentionally self-inflicted injury, within two years from the effective date of his/her coverage; or

- Your dependent dies by suicide, while sane or insane, or from an intentionally self-inflicted injury, within two years from the date of an increase in his/her coverage.

If your dependent's death occurs more than two years after the effective date of your dependent's coverage, but within two years of the date that any increase in coverage becomes effective, no death benefit will be payable for any such increased amount.

Payment of Spouse/Child Supplemental Life Insurance Benefits

You, the employee, are the beneficiary of the Spouse/Child Supplemental Life coverage. If you are deceased, the Insurer may, at its option, pay benefits to your surviving spouse or to your estate.

Termination of Spouse/Child Supplemental Life Insurance Coverage

Your Spouse/Child Supplemental Life insurance coverage under this plan ends on the earliest of the following dates that:

- You stop making required contributions in accordance with plan provisions (See the DXC **U.S. Leaves of Absence with Pay** and **DXC U.S. Leaves of Absence without Pay** policies for premium continuation requirements while on a leave of absence);
- You terminate employment with DXC;
- You no longer meet the definition of eligible employee;
- Your dependent no longer meets the definition of eligible dependent; or
- The plan ends.

Note: For dependents who lose eligibility due to turning 26 years old, their coverage will end at the end of the month of their 26th birthday.

See also **Section 14, DXC Technology Company Cafeteria Program, Period of Coverage**. The same provisions also apply to this benefit plan. Benefits may be payable if your dependent's death occurs within 31 days of the date of termination of coverage. For details, see below under **Life Insurance Conversion Privilege.**

You may be eligible to continue coverage through the **Coverage Continuation Provision, Life Insurance Portability Provision** and/or the **Life Insurance Conversion Privilege** as described below.

Provisions Applicable to Employee & Spouse/Child Coverage

Accelerated Benefit Option

The plan's Accelerated Benefit Option (ABO) feature allows you to receive a partial life insurance benefit if you or your covered spouse is under the normal retirement age, covered under the policy for at least $10,000 of life insurance, and is terminally ill. Terminally ill means that due to injury or illness, the covered person has a life expectancy of 12 or fewer months.

Important Reminder: If you have assigned your life insurance benefits or named an irrevocable beneficiary, the Insurer must receive a release from the assignee before a payment under the ABO can be made to you.

Amount of Accelerated Benefit Option Available

You may request an ABO of up to 80% of the terminally ill person's amount of life insurance, but not to exceed:

- $500,000 of Employee coverage, or

- $80,000 of Dependent coverage.

If the ABO eligible benefit is scheduled to reduce within 12 months of your request, the Insurer will calculate the ABO based on the reduced amount. (For example, if on the date you request the ABO, your coverage is $100,000, but you will turn age 70 in 4 months, the Insurer will calculate the available ABO based on a total insurance coverage amount of $65,000).

The ABO option may be exercised only once for you and only once for your spouse. For example, if you have $100,000 of coverage and are terminally ill, you can request any portion of your life insurance from $5,000 to $80,000 be paid now instead of to your beneficiary upon death. However, if you decide to request only $10,000 now, you cannot request an additional amount of ABO at a later time.

Requesting an Accelerated Benefit Option

To request the ABO, you must complete and submit an accelerated benefit claim form to the Insurer. The claim form must include:

- A statement of the amount requested; and
- A signed physician's statement verifying that you are suffering from an incurable terminal illness.

Submit the claim form to the Insurer. The Insurer may, at its own expense, require the insured to submit to an independent medical exam by a physician it chooses. The Insurer will not process your ABO request until the exam has been completed and the Insurer has received the results.

The Insurer May Refuse Your Accelerated Benefit Option Request

The Insurer may stop processing your ABO request or refuse your ABO request if:

- The ABO coverage is scheduled to end within 12 months of the date of your ABO request
- The group policy terminates coverage for your eligible class before the Insurer approves your ABO request (even if all or part of your life insurance coverage continues for any reason);
- All of your life insurance coverage terminates under the group policy for any reason before the Insurer approves your ABO request; or
- Your or your dependent dies before the Insurer issues the ABO payment.

Accelerated Death Benefit Payment

If your request is approved, the Insurer will pay you the ABO in a lump sum.

Effect of an Accelerated Benefit Option On:

Life Insurance Benefit: The amount of life insurance covering you or your dependent will be reduced by the amount of the ABO payment.

Life Conversion: An ABO payment affects the amount of life insurance you are eligible to convert to an individual policy. The converted amount will be limited to the reduced amount of life insurance after the ABO payment. Refer to the **Life Conversion** section for more information about the conversion privilege.

Accelerated Benefit Option and Claims of Creditors

To the extent allowed by law, if you are required by law to accelerate benefits to meet the claims of creditors, or if a government agency requires you to apply for benefits to qualify for a government benefit or entitlement, you will still be required to satisfy all the terms and conditions to receive the ABO.

Tax Consequences of an Accelerated Benefit Option

You may wish to carefully consider the tax consequences of requesting an ABO. Consult your counsel or tax advisor before proceeding with the request.

Important Reminder: Neither the Insurer nor DXC can offer you legal or tax advice. You should consult with your tax advisor before you request an ABO since the amount of the ABO you receive may be subject to income taxes upon receipt of the ABO payment.

Consequences of No Longer Being Terminally Ill

If you or your dependent is diagnosed by a physician as no longer being terminally ill and you return to an eligible class, coverage will remain in force provided the premium is paid, but the amount of coverage will be reduced by the ABO paid. If you or your dependent does not return to an eligible class, you may be eligible to continue coverage under the **Extension of Coverage If Disabled** provision or **Life Insurance Conversion Privilege** of this plan.

Continuation of Coverage While on Approved Leave of Absence

Your employee and spouse/child life insurance coverage may be extended while on an approved leave of absence. See the DXC **U.S. Leaves of Absence with Pay,** and **U.S. Leaves of Absence without Pay** policies, available on Employee Connect.

Amount of Coverage

The amount of continued coverage applicable to you or your dependents will be the amount of coverage in effect on the date immediately before coverage would otherwise have ended. Continued coverage:

- Is subject to any reductions in the plan;
- Is subject to payment of premium;
- May be continued up to the maximum time shown in the provisions; and
- Terminates if the policy terminates.

In no event will the amount of insurance increase while coverage is continued during any of the leave continuation provisions described below, and the leave continuation provisions may not be applied consecutively. In all other respects, the terms of your coverage and coverage for your dependents remain unchanged.

Leave Continuation Provisions

The following provisions describe continuation of coverage that is available during various types of leaves of absence.

Medical Leave of Absence: If you are not actively at work due to sickness or injury, the company will extend your Basic Employee Life coverage while you are on an approved medical leave of absence. All of your other coverages (including Spouse/Child Supplemental Life coverage) may be continued:

- For a period of 12 consecutive months from the date you were last actively at work; or
- If such absence results in a leave of absence in accordance with state or federal family and medical leave laws, then the combined continuation period will not exceed 12 consecutive months.

Family and Medical Leave: If you are granted a leave of absence, in writing, pursuant to the Family and Medical Leave Act of 1993 (FMLA), or other applicable state or local law, your coverage(s) (including company-paid Basic Employee Life) may be continued for up to 12 weeks, or 26 weeks if you qualify for Family Military Leave, or longer if required by other applicable law, following the date your leave began. If the leave of absence ends prior to the agreed upon date, this continuation will cease immediately.

Military Leave of Absence: If you enter active, full-time military service and are granted in writing a military leave of absence, your coverage (including company-paid Basic Employee Life) may be continued for up to 12 months. If the leave ends prior to the agreed upon date, this continuation will cease immediately. Other types of military leave may be entitled to continued coverage at current active employee rates for up to 30 days and at full cost for an additional 11 months.

Sabbatical Leave of Absence: If you are on a documented leave of absence, other than FMLA or Military Leave, your coverage (including company-paid Basic Employee Life coverage) may be continued for up to 30 days after the date your leave of absence began. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Continuation of Coverage for Dependent Child(ren) with Disabilities

If your dependent child(ren) reaches the age at which s/he would otherwise cease to be a dependent, his/her Child Supplemental Life coverage will not terminate solely due to age if s/he is:

- Age 26 or older; and
- Disabled; and
- Primarily dependent upon you for financial support.

However:

- You must submit proof satisfactory to the Insurer of the dependent child's disability within 31 days of the date s/he reaches age 26; and
- The dependent child must have become disabled before attaining age 26.

Disabled means your dependent child is incapable of self-sustaining employment because of a mental or physical handicap. Coverage under the policy will continue as long as:

- You remain insured;
- The child continues to meet the required conditions; and
- Any required premium is paid when due.

However, no increase in the amount of Child Supplemental Life for the disabled child will be available. In addition, the Insurer has the right to require proof, satisfactory to the Insurer, as often as necessary during the first two years of continuation coverage.

Life Insurance Portability Provision

The life insurance portability provision allows you and your dependents to continue coverage under the group portability policy when your coverage would otherwise end due to certain qualifying events.

Employee Eligibility for the Portability Provision

Basic Employee Life, Employee Supplemental Life, and Spouse/Child Supplemental Life may be continued if coverage under the group plan ends and:

- Your employment with DXC ends; or
- You are no longer in an employment classification that is eligible for such coverage (see **Employment Classifications**, in **Section 1**, above).

You may also choose to continue the reduced amount of insurance if your coverage is reduced due to:

- Your age; or
- An amendment to the Plan which affects the amount of insurance for your class.

Portability is not available to active employees if coverage terminates because:

- It is replaced by another carrier, or
- The employer goes out of business.

Dependent Eligibility for Portability Option

Your dependents may be eligible to port coverage if any of the following occur:

- Your employment terminates for any reason;
- You die;
- You are no longer a member of an eligible employee class; or
- Your dependent no longer meets the definition of dependent (however, a dependent child who reaches the limiting age under the plan is not eligible for portability).

Portability is not available if you or your dependents are entering active military service.

In addition, for your dependent child(ren) to be eligible to port coverage, you or your spouse must also elect to port coverage due to your own qualifying event.

Electing the Portability Option

To elect portability, the policy must still be in force. To elect portability for you or your dependents, you must also:

- Complete a portability application, and
- Submit the application to the Insurer, along with the required premium.

The Insurer must receive the application within the later of:

- 31 days after the applicable life insurance coverage terminates; or
- 15 days from the date your employer signs the application.

However, portability requests will not be accepted if they are received more than 91 days after Employee Supplemental Life or Spouse/Child Supplemental Life terminates.

After the Insurer verifies eligibility for coverage, it will issue a certificate of insurance under a portability policy. The portability coverage will be:

- Issued without EOI; and
- Issued on one of the forms then being issued by the Insurer for portability purposes; and
- Effective on the day following the date that your or your dependent's coverage ends.

The terms and conditions of coverage under the portability policy will not be the same terms and conditions that are applicable to coverage under the DXC group policy.

Amount of Coverage Eligible for Portability

You may elect to port life insurance that is ending for you or your dependent, subject to these limits:

Benefits	Minimum	Maximum
Employee Basic & Supplemental Life	$10,000	the lesser of your total life insurance in effect on date You elect or $1,000,000
Spouse Life	$2,500 if also porting Employee Life $10,000 if porting only Spouse Life	The lesser of your total Dependent Spouse Life Insurance in effect on the date you elect to Port or $250,000.

Child Life	$1,000	The lesser of your total Dependent Child Life Insurance in effect on the date you elect to Port or $25,000.

If your portability eligible insurance ends due to the end of the group policy, or due to an amendment to the policy which terminates the portability eligible insurance for a class for which you are a member, the maximum amount of insurance you may port is:

Benefits	The Lesser of:	
Employee Basic & Supplemental Life	Amount of your portability eligible insurance that ends under the group policy, less the amount of life insurance for which you become eligible under and replacement group policy;	Or $10,000
Spouse Life		
Child Life		

Effect of Portability on Other Provisions

Portability is not available for any amount of life insurance for which you have exercised the conversion privilege (see **Life Insurance Conversion Privilege**, below). Portability is also not available to you while your coverage is being continued under a continuation of coverage provision of the policy (see above, under **Continuation of Coverage While on Approved Leave of Absence**). However, the conversion privilege may be available for any remaining amount in the event:

- You elect to continue only a portion of terminated coverage under the portability provision; or
- The amount of life insurance exceeds the maximum amount eligible to be ported.

Life Insurance Conversion Privilege

Under certain circumstances you may be able to apply to the Insurer for an individual life insurance policy, called a “conversion policy.”

Eligibility for a Conversion Policy

You may be eligible to apply for a conversion policy if your Basic Employee Life, Employee Supplemental Life or Spouse/Child Supplemental Life coverage ends because:

- Your employment was terminated;
- You are no longer in an employment classification that is eligible for coverage (see **Employment Classifications** in **Section 1**);
- Your employment classification is no longer eligible for coverage and you have been continuously insured for at least 5 years; or
- The policy is terminated, and you have been continuously insured for at least 5 years.

You may also be eligible for a conversion policy if your coverage is reduced:

- On or after the date you attain age 70 (amount no longer available to them can be converted);
- You change from one eligible class to another; or
- The policy is amended.

A dependent will have the option to convert when:

- Coverage for that dependent ends because they cease to qualify under the terms of the plan or policy, or

- You die.

If you do not convert a reduction in coverage when it occurs, you will not be able to convert that amount at a later date.

In these circumstances, an application for conversion can be completed and submitted to the Insurer without EOI.

Amount of Coverage Eligible for Conversion

Coverage Terminated Due to Policy Changes: If you or your spouse's life insurance coverage ends because:

- The group policy is terminated; or
- The group policy is discontinued as to your employee class, the amount which may be converted is limited to the lesser of:
- $10,000; or
- The life insurance benefit under the plan less any amount of life insurance for which you or your spouse may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of this group life coverage.

Coverage Terminated for Other Reasons: If your coverage terminates for any reason other than those stated above, other than nonpayment of premium, then you may convert the full amount of your or your spouse's coverage, less any amount of life insurance for which you or your spouse become eligible under any group life insurance policy issued or reinstated within 31 days of termination of this group life coverage.

If your child's Spouse/Child Supplemental Life coverage ends for any reason except nonpayment of premium, the full amount of coverage may be converted, less any amount of life insurance for which your dependent child may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of this group life coverage.

Features of the Conversion Policy

The amount of coverage in the conversion policy will be determined at the time of application. The policy will take all of the following into consideration:

- Your age,
- The group plan's policy value in force in the prior five-year period and the current entitlement under the group plan,
- Any amount ported under the portability provision, or
- The Insurer's available products at the time of application.

The converted policy may be any kind of individual policy customarily issued at the time of conversion for the amount being converted and for your age (nearest birthday) on the date it will be issued. The provisions of the conversion policy may not be the same as the provisions of the group plan. The conversion policy may not be a term policy, may not include disability or other supplementary benefits, may contain exclusions, or may have exclusions that are different from those in the group policy. Once your individual policy becomes effective, it will replace the benefits and privileges of your former group policy.

Your Premiums and Payments for Converted Policy

The Insurer will set the premium cost for the converted policy at the customary rates in effect at the time the policy is issued. You will be responsible for making premium payments on a timely basis.

Electing Conversion

You will need to apply for an individual policy within 31 days after your group life insurance coverage ends or is reduced. To convert your life insurance coverage, you must complete a “Notice of Conversion Right” form. In addition, the Insurer must receive this form within the later of:

- 31 days after life insurance coverage terminates; or
- 15 days from the date DXC signs the form.

However, the Insurer will not accept a request for conversion if it is received more than 91 days after the life insurance terminates.

After the Insurer verifies eligibility for coverage, the Insurer will send you a conversion policy proposal. You must do the following within the time specified in the proposal:

- Complete and return the request form in the proposal; and
- Pay the required premium for coverage.

When an Individual Conversion Policy Becomes Effective

Your individual policy will become effective after the Insurer has processed your completed application and premium payment. Any individual policy issued to you or your dependents under the conversion right will be:

- Effective as of the 32nd day after the date coverage ends; and
- Will be in lieu of coverage for this amount under the policy.

Impact of Death During Conversion Period

If you or your covered dependent dies during the 31-day conversion period and before the individual policy becomes effective the Insurer will assume conversion was intended and process the claim accordingly. The amount payable is limited to the maximum amount that would have been converted to your individual policy. **This feature will apply even if the Insurer has not received a conversion application or the first premium payment for the individual policy.** The insurer will assume that conversion was intended.

Claims & Appeals

For information on how to submit a life insurance claim for benefits or appeal a decision related to a life insurance claim, please contact the insurance provider directly and reference the providers benefit booklet and certificate of coverage, incorporated herein by reference. The insurance provider is the claims administrator for your life insurance benefits. Contact information for your life insurance provider is provided in the back of this Guidebook.

Please keep in mind that a claim for life insurance benefits is subject to specific deadlines and procedures, all of which are set forth in the carrier’s benefit booklet and/or certificate of coverage.

Policy Interpretation

The Insurer has full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the policy. This provision applies where the interpretation of the policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Incontestability

Except for non-payment of premiums, you or your dependent's life insurance benefit cannot be contested after two years from its effective date. After your insurance has been in force for two years, no statement made by you or your spouse relating to your or his/her insurability will be used to contest your insurance for which the statement was made. To be used, the statement must be in writing and signed by you and your spouse.

After their insurance has been in force for two years, no statement made relating to your dependents being insurable will be used to contest their insurance for which the statement was made. To be used, the statement must be in writing and signed by you or your representative.

All statements made by the policy holder, employer, you, or your spouse under policy will be deemed representations and not warranties. No statement made to affect this insurance will be used in any contest unless it is in writing and a copy of it is given to the person who made it, or to his/her beneficiary or representative.

Assignment of Rights

You have the right to assign all of your rights and interest under the policy including, but not limited to, the following:

- The right to make any contributions required to keep the insurance in force;
- The right to convert; and
- The right to name and change a beneficiary.

The Insurer will recognize any absolute assignment made by you under the policy, provided:

- It is duly executed; and
- A copy is acknowledged and on file with the Insurer

The Insurer and the policyholder assume no responsibility:

- For the validity or effect of any assignment; or
- For providing any assignee with notices which the Insurer may be obligated to provide to you. You do not have the right to collaterally assign your rights and interest under the policy.

The Insurer will recognize the rights of assignee if:

- A writing, in a form satisfactory to the Insurer, is completed which describes the assignment of rights;
- The form is signed both by you (the assignor) and the assignee
- The policyholder (Computer Sciences Corporation dba DXC Technology Company) acknowledges that the coverage being assigned is in force with regard to the assignor
- The writing is submitted to the Insurer, and the Insurer is satisfied with its completeness. The Insurer will not be responsible for determining the validity of the assignment.

Legal Actions

Legal action cannot be taken against the Insurer:

- Earlier than 60 days after the date written proof of loss is furnished; or
- More than 6 years after the date proof of loss was required to be furnished according to the terms of the policy.

Workers' Compensation

The policy does not replace workers' compensation or affect any requirement for workers' compensation coverage.

Fraud

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may have violated state law and may face adverse consequences with the Company and law enforcement offices.

Misstatements

If material facts about you or your dependents were not stated accurately:

- The premium may be adjusted; and
- The true facts will be used to determine if, and for what amount, coverage should have been in force.

Life Insurance Coverage Upon Retirement

Employees who participate in a grandfathered retiree medical plan may also be eligible under that plan for $5,000 of Basic Employee Life Insurance coverage upon termination.

Upon termination, eligible employees will receive a separate booklet outlining retiree benefits, and the provisions and conditions in more detail.

Certificate of Insurance

A separate certificate of insurance will not be issued. You may obtain a copy of the Insurer's certificate of insurance booklet from the DXC Benefits Center portal myDXCbenefitscenter.com, and such booklet is incorporated herein by reference.

This SPD explains the general purposes of the insurance described. In the event of any discrepancy between the SPD and certificate of insurance booklet, the certificate of insurance booklet applies.

Contacting the Carrier

Contact information for all benefit carriers is provided in the back of this Guidebook.

Section 8

Accidental Death & Dismemberment Insurance Plans

Accidental Death & Dismemberment Insurance Plans

General Information, Eligibility & Enrollment

Introduction

DXC automatically provides Employee Basic Accidental Death & Dismemberment (Basic AD&D) coverage for all eligible employees. DXC also offers voluntary, employee-paid Employee Supplemental AD&D (Supplemental AD&D) options. Contributions for Supplemental AD&D are made on a pre-tax basis.

This plan is insured and administered by Zurich American Insurance Company (Zurich or the Insurer).

For purposes of Basic AD&D and Supplemental AD&D, base annual earnings (BAE) means your annual base compensation, rounded to the next higher $1,000 increment, if not already an even multiple of $1,000 (excluding overtime, shift differential, bonuses, living or other allowances).

If you are covered by a formal sales incentive plan at the beginning of the payroll year, your premium and benefits will be calculated at the beginning of that payroll year and remain unchanged for the payroll year (as long as you continue to be an eligible enrolled employee). The calculation will include your usual base rate of pay on the last day of the prior payroll year, plus paid draws and any paid formal sales incentive amounts that exceed the draw amounts paid in the preceding payroll year.

Any change in the amount of coverage due to a change in compensation will not take effect unless, and until, an employee is at work.

For convenient reference in this Guidebook, Basic AD&D and Supplemental AD&D plans are described as separate plans. These benefits are provided through a sub-part of the same ERISA benefit plan through which other fully insured benefits are provided (such as Spouse/Child Supplemental Life and disability coverages). That ERISA plan is plan number 502.

For a list of participating employers for the overall ERISA plan of which this coverage is a part, see **Section 15, ERISA Information**. Section 15 also shows whether a participating employer offers the Basic AD&D and Supplemental AD&D Plans to its employees. Not all employers offer this coverage. Also, some participating employers only offer this coverage to certain employee groups. See **Section 15, ERISA Information** for more information.

Employee Eligibility

For AD&D coverage, you are subject to the same provisions and definitions regarding eligibility as set forth in **Section 2, Medical Plans.**

You are eligible for coverage in the Basic AD&D and Supplemental AD&D plans on the first day you report to work.

If you do not meet the eligibility requirements on the first day you report to work, but later meet them due to a change in employment status from temporary, casual or part-time, you will become eligible at that time.

Enrollment/Effective Date of AD&D Coverage

Basic AD&D

Participation in the Basic AD&D Plan is automatic; it does not require enrollment. Coverage is effective on the date you are first eligible for this coverage.

Enrolling in Supplemental AD&D Coverage

Employee Supplemental AD&D is a voluntary plan that requires enrollment. You can enroll yourself in Supplemental AD&D coverage at one of the following times:

1. Within 30 days of your hire date (or initial date of eligibility) or by the deadline on your enrollment notice (whichever is later); or
2. During the Annual Benefits Open Enrollment period; or
3. Within 30 days of a qualified change of status, special enrollment, or a specifically permitted event (all as described in **Section 14, DXC Technology Company Cafeteria Program** under **Changing Your Cafeteria Plan Elections)**

To enroll, you must complete your enrollment online by accessing the DXC Benefits Center portal (myDXCbenefitscenter.com) or by calling 1.888.305.5499.

The consequences for not enrolling in Supplemental AD&D benefits are as follows:

- If you do not enroll within one of the periods described above, your Supplemental AD&D election will default to waiver of coverage.
- If the annual enrollment period requires active enrollment for the following plan year, and you do not enroll, your Supplemental AD&D election will default to waiver of coverage.

It is your responsibility to review your remuneration statement (paystub) to confirm deductions accurately reflect your elections.

Your election is irrevocable and binding. Your next opportunity to enroll or make enrollment changes will be during the Annual Benefits Open Enrollment period, unless you have a qualified change of status, are eligible for a special enrollment, or have another specifically permitted event as described in **Section 14, DXC Technology Company Cafeteria Program** under **Changing Your Cafeteria Plan Elections**. The same provisions also apply to this benefit plan.

Effective Date of Supplemental AD&D Coverage

Enrollment Event	Effective Date
New hire/newly eligible	Retroactive to hire date/initial date of eligibility
Annual Benefits Open Enrollment	January 1 of new plan year
Qualified change of status, special enrollment, or specifically permitted event	Date of election

Deferred Effective Date Provision

The effective dates above are subject to the deferred effective date provision. If you are absent from work due to sickness or injury on the date coverage or an increase in coverage would have otherwise been effective, the effective date of coverage will be deferred until you have returned to active work for one full work day.

Annual Benefits Open Enrollment/Changing Your Elections

Annual Benefits Open Enrollment Period

Once each year, you have an opportunity to change your Supplemental AD&D elections. The Annual Benefits Open Enrollment (Annual Enrollment) period is usually held in October/November for an effective date of January 1 of the new plan year.

The elections you make during the Annual Enrollment period, including default elections, are irrevocable and binding until the next Annual Enrollment period unless you are eligible to change your elections as described in **Section 14**, under **Changing Your Cafeteria Plan Elections**. The same provisions also apply to this benefit plan.

Unless the company communicates otherwise prior to Annual Enrollment, your Supplemental AD&D coverage will continue each year as previously elected, but at new plan year prices, unless you make a change during the Annual Enrollment period. This must not be interpreted as a promise or guarantee that the same benefit plans will be available to you from one year to the next. (See **Introduction** on **page 8-1**, above.)

Changing Your Elections

See Section 14, DXC Technology Company Cafeteria Program under Changing Your Cafeteria Plan Elections.

The same provisions also apply to this benefit plan.

Cost of Participation in the Accidental Death & Dismemberment Plan

Cost of Basic AD&D

DXC pays 100% of the cost to provide eligible employees with Basic AD&D insurance coverage.

Cost of Supplemental AD&D

You pay the full cost of Supplemental AD&D. The cost of participating in Supplemental AD&D is available on the DXC Benefits enrollment portal when you are ready to enroll.

Pre-Tax Contribution for Supplemental AD&D Coverage

Your contributions for your elected Supplemental AD&D coverage will be taken from your gross salary through payroll deductions before federal income taxes are calculated and before state income taxes are calculated (in states where legally permitted). Your pre-tax contributions are governed by and pursuant to the **Pre-Tax Contribution Plan**, which is a component plan of the **DXC Technology Company Cafeteria Program** described in **Section 14**.

Benefits Provided

A summary of key terms is provided below. In the event of a conflict between the benefits described here, and benefits described in the applicable carrier's Certificate of Coverage, the Certificate of Coverage shall control.

Coverage Levels

Basic AD&D Insurance Coverage (Company-Paid)

DXC provides Basic AD&D insurance coverage to eligible employees in an amount equal to 100% of base annual earnings (BAE), see **page 8-1**.

Supplemental AD&D Insurance Coverage (Employee-Paid)

In addition to your Basic AD&D insurance coverage, you may elect Supplemental AD&D insurance coverage. The amount of your Supplemental AD&D coverage may be equal to one, two, three, four or five times your BAE (see **page 8-1)**, subject to maximum benefit coverage provisions.

Basic and Supplemental Life benefits for SCA/Individual Wage Determination and employees covered by collective bargaining agreements (CBAs) may vary.

Maximum AD&D Insurance Coverage

Basic and Supplemental AD&D insurance coverages combined may not exceed $1,000,000.

Benefit Reductions

Your Basic and any Supplemental AD&D insurance coverage will be reduced in accordance with the table below on the date you attain the age indicated. These reductions also apply if you become covered or your coverage increases on or after the date you attain age 70.

Age	Amount By which Benefit is Reduced
70	35%
75	55%
80	70%

Regardless of age, no employee's principal sum amount will be less than $5,000. Any reductions in coverage amount, because of age, take place on your birthday.

Payment of AD&D Benefits

Please refer to the benefit booklet / certificate of coverage provided by the Insurer, incorporated herein by reference, to review (i) the schedule of benefits that will be paid for different types of accidental loss occurring within one year of the covered accident, (ii) the additional safety device benefit, (iii) coma benefit, (iv) terrorism benefit, (v) felonious assault benefit, (vi) home alteration and vehicle modification benefit, (vii) rehabilitation benefit, and (viii) therapeutic counseling benefit. All of these benefits are subject to specific terms and conditions which determine whether the benefit is available to you under applicable circumstances.

Provisions Pertaining to Specific Circumstances

Coverage provided under the AD&D plan includes injury sustained due to specific circumstances (i.e., exposure to the elements resulting in a covered loss, hijacking, etc.). Please refer to the benefit booklet / certificate of coverage provided by the Insurer, incorporated herein by reference, to review the benefits available to you under specific circumstances, and the terms and conditions applicable to such benefits.

Exclusions

No benefit will be paid for loss, fatal or nonfatal, caused by or resulting from specific excluded circumstances. Please refer to the benefit booklet / certificate of coverage provided by the Insurer, incorporated herein by reference, to review the exclusions to which this policy does not apply.

Claims & Appeals

For information on how to submit an AD&D insurance claim for benefits or appeal a decision related to an AD&D insurance claim (Policy Number: GTU 0207328), please contact the insurance provider directly and reference the providers benefit booklet and certificate of coverage, incorporated herein by reference. The insurance provider is the claims administrator for your AD&D benefits. Contact information for your AD&D insurance provider is provided in the back of this Guidebook.

Please keep in mind that a claim for AD&D benefits is subject to specific deadlines and procedures, all of which are set forth in the carrier's benefit booklet and/or certificate of coverage.

Beneficiary

Election of Beneficiary(ies)

You select the beneficiary. You may elect or change your beneficiary on the DXC Benefits Center portal at myDXCbenefitscenter.com.

Payment of Benefits to Beneficiaries

Unless you have requested something different, payment will be made as follows:

1. If more than one beneficiary is named, each will be paid an equal share, or as designated by you on your beneficiary form.
2. If any named beneficiary dies before you, his/her share will be divided equally among the named surviving beneficiaries.

Payment Where No Beneficiary is Named or No Beneficiary Survives You

If no beneficiary is named, or if no named beneficiary survives you, the Insurer, at its option, may pay:

1. All to your surviving spouse;
2. If your spouse does not survive you, in equal shares to your surviving children;
3. If no child survives you, in equal share to your surviving parents;
4. If there are no living parents, in equal shares to your living brothers and sisters; or
5. If there are no living brothers or sisters, to your estate.

Termination Of Coverage and Continuation Options

Termination of AD&D Insurance Coverage

Your Basic AD&D insurance coverage under this plan ends on the earlier of the following dates that:

- You terminate employment with DXC;
- You no longer meet the definition of eligible employee; or
- The plan ends.

Your Supplemental AD&D insurance coverage under this plan ends on the earlier of the following dates that:

- You stop making required contributions in accordance with plan provisions (See the DXC **U.S. Leaves of Absence with Pay** and **DXC U.S. Leaves of Absence without Pay** policies for premium continuation requirements while on a leave of absence);
- You terminate employment with DXC;
- You no longer meet the definition of eligible employee; or
- The plan ends.

Also see **Section 14, DXC Technology Company Cafeteria Program, Period of Coverage**. The same provisions also apply to this benefit plan.

AD&D Conversion Privilege

If you are under age 70 and your coverage ends because you cease to be eligible (for reasons other than age or termination of the policy), or due to termination of employment, you may apply for an individual AD&D (IAD) policy. The new IAD policy will be on approved forms and will not include all the benefits and additional benefits of the group policy. The Insured must make a written application for the IAD policy within sixty (60) days of the cessation of coverage under the group policy. To request a Conversion Application Form, the Insured must call 1.800.834.1959. The Insured does not have to show proof of good health.

The issuance of the IAD policy is subject to the following conditions:

- The Principal Sum for the IAD policy will be the lesser of the Insured's principal sum under the Basic AD&D or $100,000;
- The premium for the IAD policy will be the rate on file with the proper regulatory authority, if such filing is required;
- Any IAD policy issued will take effect on the termination date of the Insured's insurance under the Basic AD&D Policy; and
- When an IAD policy becomes effective, the relationship between the Insured and the Insurer will be governed by that policy, including all terms and conditions, and benefits and termination dates.

Availability of the conversion privilege will cease when the Insured attains age 70.

Section 9

Business Travel Accident Plan

Business Travel Accident Insurance

For Business Travel Accident Insurance (BTA), DXC has partnered with Zurich American Insurance Company, “Zurich”, (the Insurer). The BTA program is now described in a separate document, the DXC Technology Company Business Travel Accident Insurance Guidebook, which is available on mydxcbenefits.com and incorporated by reference herein.

Section 10

Short-Term Disability Insurance Plan

Short-Term Disability Insurance Plan

General Information, Eligibility & Enrollment

Introduction

DXC offers Short-Term Disability (STD) coverage as an optional, employee-paid benefit. Contributions are made by employees on a post-tax basis; therefore, any STD benefits you receive that are attributable to your post-tax contributions are not taxable.

This plan is insured and administered by The Hartford (Hartford or the Insurer).

With respect to terms used in this section, please refer to the benefit booklet / certificate of coverage provided by the Insurer for a complete list of definitions and applicable terms and conditions.

For convenient reference in this Guidebook, the STD plan is described as a separate plan. These benefits are provided through a sub-part of the ERISA plan (plan number 502) through which other benefits are provided (such as life insurance and accidental death & dismemberment coverages). See **Section 15, ERISA Information.**

For a list of participating employers for the overall ERISA plan of which this coverage is a part, see **Section 15, ERISA Information**. **Section 15** also shows whether a participating employer offers the STD plan to its employees. Not all employers offer this coverage. Also, some participating employers only offer this coverage to certain employee groups. See **Section 15, ERISA Information** for more information.

Employee Eligibility

For STD coverage, you are subject to the same provisions and definitions regarding eligibility as set forth in **Section 2, Medical Plans.**

You are eligible to enroll for coverage in the STD plan on the first day you report to work if you satisfy the applicable eligibility requirements.

If you are enrolled in this plan but are absent from work due to injury or sickness on the day this coverage would normally begin, you will be covered when you report to work on a regular, full-time basis for a period of at least one full day. See below under “Deferred Effective Date Provision” for more information.

Enrollment/Effective Date of Short-Term Disability Coverage

Enrolling in Short-Term Coverage

Beginning January 1, 2024, new hires will be automatically enrolled in STD coverage (30-day option) but have 30 days to elect to change or waive coverage (see below, Short-Term Disability Plan Options).

For existing employees, Employee STD coverage is a voluntary plan that requires enrollment. You can enroll yourself in STD coverage at one of the following times:

- Within 30 days of your hire date (or initial date of eligibility) or by the deadline on your enrollment notice (whichever is later);
- During the Annual Benefits Open Enrollment period; or
- Within 30 days of a qualified change of status, special enrollment, or a specifically permitted event (all as described in **Section 14, DXC Technology Company Cafeteria Program** under **Changing Your Cafeteria Plan Elections).**

To enroll, access the DXC Benefits Center portal (myDXCbenefitscenter.com) or call 1.888.305.5499.

The consequences for not enrolling in STD are as follows:

- If you do not enroll within one of the periods described above, your STD election will default to waiver of coverage.
- If the annual enrollment period requires active enrollment for the following plan year, and you do not enroll, your STD election will default to waiver of coverage.

It is your responsibility to review your remuneration statement (paystub) to confirm deductions accurately reflect your elections.

Your election is irrevocable and binding. Your next opportunity to enroll or make enrollment changes will be during the Annual Benefits Open Enrollment period, unless you have a qualified change of status, are eligible for a special enrollment, or have another specifically permitted event as described in **Section 14, DXC Technology Company Cafeteria Program** under **Changing Your Cafeteria Plan Elections**. The same provisions also apply to this benefit plan.

Effective Date of Short-Term Disability Coverage

Enrollment Event	Effective Date
New hire/newly eligible	Hire date/initial date of eligibility
Annual Benefits Open Enrollment[1]	January 1 of new plan year or retroactiveto date Insurer approves EOI (if required) – whichever is later
Qualified change of status, special enrollment, or specifically permitted event[1]	Retroactive to date Insurer approves EOI (if required)

1. Evidence of Insurability is required if you are enrolling or increasing coverage (e.g., changing from a 30-day waiting period to a 7-day waiting period plan)

Deferred Effective Date Provision

The effective dates above are subject to the deferred effective date provision. If on the date coverage or an increase in coverage would have otherwise been effective, you are absent from work due to any of the reasons below, the effective date of coverage will be deferred until you have returned to active work for one full workday:

- Accidental bodily injury
- Sickness
- Mental illness
- Substance abuse
- Pregnancy

Evidence of Insurability

Evidence of Insurability (EOI) is required for certain enrollment events. If applicable, enrollments or increases to STD coverage will not be effective until the Insurer approves your EOI statement. No EOI is required if you are reducing your coverage (e.g., moving to an STD plan option with a longer waiting period. See below under **Short-Term Disability Plan Options**).For coverage that requires EOI, the Insurer may still deny coverage after receipt and review of the required documentation. EOI may include, but is not limited to:

- Completed, signed application

- Medical exam
- Attending physician statement
- Any other information the Insurer may require.

EOI and Short-Term Disability Insurance

EOI requirements for STD enrollment are shown in the following table:

Enrollment Event	EOI Required?
New hire/ newly eligible	No
Annual Benefits Open Enrollment[1]	Yes
Qualified change of status, special enrollment, or specifically permitted event[1]	Yes

1. Includes initial enrollment and increases in coverage (e.g., changing from a 30-day waiting period to a 7-day waiting period plan)

Elections requiring EOI will not be effective unless the Insurer approves your application (see **Annual Benefits Open Enrollment Period/Changing Your Elections**). See above under **Effective Date of Short-Term Disability Coverage** for when coverage elections requiring EOI are effective.

Impact of Unsatisfactory EOI

If your EOI is not satisfactory to the Insurer, **you will not be covered under the policy for the coverage subject to EOI**. If you submitted EOI to increase coverage from the 30-day waiting period option to the 7-day waiting period option, and your EOI is not satisfactory to the Insurer, you will retain your STD coverage under the 30-day waiting period option.

How to Submit EOI

When you enroll in the DXC Benefits Center enrollment portal (myDXCbenefitscenter.com) for coverage requiring EOI, a link to the Insurer's EOI processing website will appear in the enrollment workflow. Please follow the link for instructions on submitting EOI.

Annual Benefits Open Enrollment/Changing Your Elections

Annual Benefits Open Enrollment Period

Once each year, you have an opportunity to change your STD election. The Annual Benefits Open Enrollment (Annual Enrollment) period is usually held in October/November for an effective date of January 1 of the new plan year. See above under **EOI and Short-Term Disability Insurance**, above, for changes requiring EOI. See also **Effective Date of Short-Term Disability Coverage,** above, for when coverage elections requiring EOI are effective.

The elections you make during the Annual Enrollment period, including default elections, are irrevocable and binding until the next Annual Enrollment period unless you are eligible to change your elections as described in **Section 14**, under **Changing Your Cafeteria Plan Elections**. The same provisions also apply to this benefit plan.

Unless the company communicates otherwise prior to Annual Enrollment, your STD coverage will continue automatically each year as previously elected, but at new plan year prices, unless you make a change during the Annual Enrollment period. This must not be interpreted as a promise or guarantee that the same benefit plans will be available to you from one year to the next. (See **Introduction** on **page 10-1**, above.)

Changing Your Elections

See **Section 14, DXC Technology Company Cafeteria Program under Changing Your Cafeteria Plan Elections**. The same provisions also apply to this benefit plan.

Cost of Participation in the Short-Term Disability Plan

You pay the full cost of STD coverage. The cost of participating in STD is available on the enrollment site when you are ready to enroll. The cost is based on the state in which you work. Contributions under collective bargaining agreements (CBAs) may vary. See your CBA for details, if applicable.

Post-Tax Contribution for Short-Term Disability Coverage

Your contributions for your elected STD coverage will be taken from your gross salary through payroll deductions after applicable federal income taxes and state income taxes are calculated. However, benefits you receive through the DXC STD Plan that are attributable to your post-tax contributions are not taxable.

Benefits Provided

A summary of key terms is provided below. In the event of a conflict between the benefits described here, and benefits described in the applicable carrier's benefit booklet or Certificate of Coverage, incorporated herein by reference, the Certificate of Coverage shall control.

Short-Term Disability Plan Options

The STD plan gives you the option of electing one of two Elimination Periods. An Elimination Period is the period of time you must be continuously disabled before benefits become payable. Your two options are:

- **Option 1 – Seven-Day Elimination Period:** benefits will commence on the 8th day of your approved disability
- **Option 2 – Thirty-Day Elimination Period:** benefits will commence on the 31st day of your approved disability

Once you have elected an option, any changes are subject to rules regarding changing your elections and may require EOI. See above, under **Enrollment/Effective Date of Short-Term Disability Coverage.** See also, **Evidence of Insurability** and **Annual Benefits Open Enrollment/Changing Your Elections**.

Test of Disability

To receive benefits, you must first meet the Test of Disability. You meet the Test of Disability if you are not able to perform the material duties of your own occupation because of an illness or injury, or because of a pregnancy-related condition. You are not performing the material duties of your own occupation if:

- You are only performing some of the material duties of your own occupation; and
- Your income is 80% or less of your pre-disability earnings solely because of an illness, injury or a disabling pregnancy-related condition.

The loss of a professional or occupational license or certification that is required by your own occupation does not mean that you meet the Test of Disability. You must meet this plan's Test of Disability, as determined by the Insurer, to be considered disabled.

Short-Term Disability Benefit Period

Once you meet the STD Test of Disability described above, your STD benefits will begin on the next day after you complete the elimination period of the option you elected. The elimination period is the amount

of time you must be disabled before benefits start. No benefit is payable for or during the elimination period. You must be under the care of a physician and provide satisfactory proof of disability to the Insurer.

Your STD benefits will be payable for as long as your disability benefit eligibility continues, but not beyond the end of the maximum weekly benefit period. The elimination periods and the maximum weekly benefit period for approved claims are shown in the following schedule of benefits:

Option 1 (7-Day Elimination Period): Weekly benefits are payable beginning on the 8th day of your disability. Your benefit will continue until the earliest of 26 weeks (including the 7-Day Elimination Period), or when you are no longer disabled, or when Long-Term Disability monthly benefits commence (if enrolled).

Option 2 (30-Day Elimination Period): Weekly benefits are payable beginning on the 31st day of your disability. Your benefit will continue until the earliest of 26 weeks (including the 30-Day Elimination Period), or when you are no longer disabled, or when Long-Term Disability monthly benefits commence (if enrolled).

For Disability caused by childbirth: benefits commence on the earlier of:
1) the benefit commencement date above; or
2) the date of delivery.

Short-Term Disability Benefits Payable

STD benefit payments are 60% of your weekly pre-disability base earnings (excluding commissions, bonuses, overtime pay, or any other pay or fringe benefits). They are payable on a weekly basis, reduced by income you receive from “other income benefits” as explained below and are subject to a maximum benefit of $3,462 per week. Benefits will be paid at the end of each week during the period for which benefits are payable. Weekly benefits for a period less than a week will be prorated. This will be done on the basis of the ratio to seven days of the days of eligibility for benefits during the week.

Because you pay for this coverage on a post-tax basis, the benefits you receive through the DXC STD plan that are attributable to your post-tax contributions are not taxable.

The weekly benefit is based on your pre-disability earnings, up to the maximum weekly benefit shown in the schedule of benefits. To calculate your weekly STD benefit, multiply:

- Your pre-disability earnings; times
- The weekly benefit percentage shown in the schedule of benefits.

The benefit payable will be the lesser of:

- The weekly benefit; and
- The maximum weekly benefit.

Any other income benefits you are eligible for may affect your benefits from this plan. The amount of the other income benefits will be subtracted from your weekly STD benefits for which you are eligible. Please refer to the **Effect of Other Income on Short-Term Disability Benefits** section of this SPD for details as to which other income benefits may reduce your weekly benefit.

Any change in the amount of coverage due to a change in compensation will not take effect unless and until an employee is at work.

Benefits During Family & Medical Leave (FMLA)

Your benefits coverage may be extended while on an approved leave of absence. See the **DXC U.S. Leaves of Absence with Pay**, and **U.S. Leaves of Absence without Pay** policies and also the **DXC Leaves of Absence Guide**, available in Employee Connect.

DXC employees on an approved FMLA leave will be required to use all available paid leave (accrued sick leave and/or flexible vacation, as applicable) in accordance with established guidelines governing the use of paid leave, see the DXC **U.S. Sick Leave** and **U.S. Flexible Vacation** policies, available in Employee Connect. If you are enrolled in the voluntary STD plan, you are not required to file an STD claim and may use paid leave for the entire FMLA covered absence. However, if you decide to file a claim for STD benefits, you must use sick and/or flexible vacation leave during your elimination period. At the end of the elimination period, the use of sick and vacation, if applicable, leave will stop, and any sick and vacation leave you have accrued up to that date will be held in suspense until you return to work.

You are not entitled to use sick and vacation leave in lieu of disability benefits, during the period a claim is being evaluated by the carrier, while receiving disability benefits, or in conjunction with disability benefits. However, you may use accrued sick and/or flexible vacation leave in the event a disability claim is denied or discontinued.

DXC paid time off (e.g., sick leave, flexible vacation) may be used during the Short-Term Disability elimination period and while you are on Family & Medical Leave (FMLA) but may not be used once STD benefits become payable. STD benefits will be reduced by any pay received from DXC. Any unused sick leave and vacation will remain available for use upon your return to work.

When Short-Term Disability Benefits End

You will no longer be considered disabled or eligible for weekly benefits when the first of the following occurs:

1. The date you no longer meet the STD test of disability, as determined by the Insurer
2. The date you are no longer under the regular care of a physician
3. The date you fail to provide proof that you meet the STD test of disability
4. The date you refuse to be examined by or cooperate with an independent physician, or a licensed and certified health care practitioner, as requested. The Insurer has the right to examine and evaluate you at any reasonable time while your claim is pending or payable (the examination or evaluation will be done at the Insurer's expense)
5. The date an independent medical exam report or functional capacity evaluation does not, in the Insurer's opinion, confirm that you are disabled
6. The date you reach the end of your maximum benefit period, as shown in the schedule of benefits
7. The date you are not receiving effective treatment for alcoholism or drug abuse, if alcoholism and drug abuse are the cause (or part of the cause) of your disability
8. The date you refuse to cooperate with or accept:
    a. Changes to your work site or job process designed to suit identified medical limitations, or
    b. Any adaptive equipment or devices designed to suit your identified medical limitations that would allow you to perform your own occupation. This applies only if a physician agrees that such changes, adaptive devices or equipment suit your particular medical limitations
9. The date you refuse any treatment recommended by your attending physician that, in the Insurer's opinion, would cure, correct or limit your disability
10. The date your work condition would permit you but you refuse to:
    a. Work; or
    b. Increase the hours you work; or
    c. Increase the number or type of duties you perform in your own occupation

11. The date you become eligible for benefits under any other disability plan of this type that is offered by DXC if this date falls after the date the group contract ends
12. The date your current weekly earnings are equal to or greater than 80% of your pre-disability earnings you are receiving benefits for being disabled from your occupation
13. The day after the Insurer determines that you can participate in an approved rehabilitation program and you refuse to do so
14. The date of your death

Recurrent Disabilities

Once you no longer meet the STD test of disability, any new disability will be treated separately. However, two or more disabilities will be considered as the same disability if they are due to the same condition or cause; and separated by fewer than 30-days in a row of active work. In this case only, one elimination period will apply. The first disability will not be included if it began while you were not covered.

If you return to work as an active employee for 30 consecutive calendar days or more, any recurrence of a disability will be treated as a new disability.

Multiple Causes

If a period of disability is extended by a new cause while weekly STD benefits are payable, the weekly benefits will continue while you remain disabled subject to the following:

- Weekly benefits will not continue beyond the end of the original maximum duration of benefits; and
- Any exclusions will apply to the new cause of disability.

Effect of Other Income on Short-Term Disability Benefits

Other income and benefits (i.e., Social Security) you receive while covered by STD benefits may impact the amount of STD benefits you receive. Please refer to your benefit booklet / certificate of coverage for details regarding which income affects your STD benefits and the impact of that income on your STD benefits.

Exclusions

STD coverage does not cover any disability on any day that you are confined in a penal or correctional institution for conviction of a criminal act or other public offense. You will not be considered to be disabled, and no benefits will be payable.

STD coverage also does not cover any disability that is:

- Not under the regular care of a physician
- Caused by or contributed to by war or any act of war (declared or not declared)
- Caused by or contributed to by an intentional self-inflicted injury (while sane or insane)
- Caused by or contributed to by your commission of, or attempt to commit, a criminal act
- Caused by or contributed to by your being engaged in an illegal occupation
- Covered by worker’s compensation and for which worker’s compensation benefits are being paid, or may be paid if duly claimed
- Sustained as a result of doing any work for pay or profit from another employer, including self-employment
- Covered under a prior disability plan sponsored by your employer that was terminated before the effective date of this policy and for which you are receiving or eligible to receive benefits.

Claims & Appeals

For information on how to submit an STD insurance claim for benefits or appeal a decision related to an STD insurance claim, please contact the insurance provider directly and reference the providers benefit booklet and certificate of coverage, incorporated herein by reference. The insurance provider is the claims administrator for your STD benefits. Contact information for your STD insurance provider is provided in the back of this Guidebook.

Please keep in mind that a claim for STD benefits is subject to specific deadlines and procedures, all of which are set forth in the carrier's benefit booklet and/or certificate of coverage.

Termination Of Coverage and Continuation Options

Coverage under your plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

Termination of STD Coverage

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions, see **Continuation of STD Coverage While on Approved Leave of Absence**, below;
- You become covered under another plan offered by DXC; or
- Your DXC employment ends for any reason, including job elimination or being placed on severance.

Continuation of STD Coverage While on Approved Leave of Absence

DXC may extend your STD coverage while you are on an approved disability leave of absence. You may elect to extend your STD coverage during the period of approved leave by paying the full cost of the coverage to the DXC Benefits Center. (See the **DXC U.S. Leaves of Absence without Pay**, and the **DXC U.S. Leaves of Absence with Pay** policies and the DXC Leaves of Absence Guide available in Employee Connect)

Sabbatical Leave of Absence (formerly called Personal Leave)

If you are on a documented leave of absence, other than Family & Medical Leave Act (FMLA) or Military Leave, your coverage may be continued for 12 months after the month in which the leave of absence began. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Military Leave of Absence

If you are on active-duty full-time military service and are granted a military leave of absence in writing, your coverage may be continued for up to 12 months. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Family and Medical Leave (FMLA) and Medical Leave

If you are granted a leave of absence, in writing, pursuant to the Family and Medical Leave Act of 1993, other applicable state or local law, or DXC Medical Leave policy, your coverage(s) (including STD coverage) may be continued for the duration of the Family Medical Leave or up to one calendar year from

the effective date of the Medical Leave (whichever is shorter). If the leave of absence ends prior to the agreed upon date, this continuation will cease immediately.

Leave Due to Disability

If you are disabled, your STD coverage will be continued:

- While you remain disabled; and
- Until the end of the period for which you are entitled to receive STD benefits, provided you continue to pay premiums.

After your STD payments have ceased, your insurance will be reinstated, provided you:

- Return to work for one full day as a full-time active employee in an eligible class;
- The policy remains in force; and
- The premiums were paid during your disability and continue to be paid.

Extension of Short-Term Disability Coverage and Benefits

If you are entitled to STD benefits while disabled and the policy terminates, benefits:

- Will continue as long as you remain disabled by the same disability; and
- Will not be provided beyond the date the Insurer would have ceased to pay benefits had the policy remained in force.

General Terms Applicable to Short-Term Disability

Overpayment

Definition of Overpayment

An overpayment occurs:

- When the Insurer determines that the total amount it has paid in benefits is more than the amount that was due to you under the policy; or
- When payment is made by the Insurer that should have been made under another group policy.

This includes, but is not limited to, overpayments resulting from:

- Retroactive awards received from sources listed in the **Other Income Benefits that Reduce Weekly Short-Term Disability Benefits** section, above;
- Failure to report, or late notification to the Insurer of any earned income or income listed in **Other Income Benefits that Reduce Weekly Short-Term Disability Benefits**;
- Misstatement;
- Fraud; or
- Any error by the Insurer.

Recovery of Overpayment

The Insurer has the right to recover from you any amount that it determines to be an overpayment. You have the obligation to refund any such amount to the Insurer. The Insurer's right and your obligations in this regard may also be set forth in the reimbursement agreement you will be required to sign when you become eligible for benefits under the policy.

If benefits are overpaid on any claim, you must reimburse the Insurer within 30 days. If reimbursement is not made in a timely manner, the Insurer has the right to:

1. Recover such overpayments from:
   a. You;
   b. Any other organization;
   c. Any other insurance company;
   d. Any other person to or for whom payment was made; and
   e. Your estate;
2. Reduce or offset against any future benefits payable to you or your survivors, until full reimbursement is made; payments may resume when the overpayment has been recovered;
3. Refer your unpaid balance to a collection agency; and
4. Pursue and enforce all legal and equitable rights in court.

Subrogation

The Insurer will be subrogated to any rights you may have against a third party if you:

- Suffer a disability because of the act or omission of a third party; and
- Become entitled to and are paid benefits under the policy; and
- Do not initiate legal action for the recovery of such benefits from the third party within a reasonable period of time.

Accordingly, the Insurer may, at its option, bring legal action against the third party to recover any payments the Insurer has made in connection with the disability.

Third party as used in this provision, means any person or legal entity whose act or omission, in full or in part, causes you to suffer a disability for which benefits are paid or payable under the policy.

Reimbursement

The Insurer has the right to request reimbursement for any benefit payments made or required to be made under the policy for a disability for which you recover payment from a third party. If you recover payment from a third party as the result of:

- A legal judgment;
- An arbitration award; or
- A settlement or otherwise;

Then you must reimburse the Insurer for the lesser of the:

- Amount of payment made or required to be made by the Insurer; or
- Amount recovered from the third party less any reasonable legal fees associated with the recovery.

Third party as used in this provision, means any person or legal entity whose act or omission, in full or in part, causes you to suffer a disability for which benefits are paid or payable under the policy.

Policy Interpretation

The Insurer has full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the policy. This provision applies where the interpretation of the policy is governed by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Legal Actions

Legal action cannot be taken against the Insurer:

- Earlier than 60 days after the date written proof of loss is furnished; or
- More than 3 years after the date proof of loss was required to be furnished according to the terms of the policy.

Fraud

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may have violated state law.

Misstatements

If material facts about you or your dependents were not stated accurately:

- The premium may be adjusted; and
- The true facts will be used to determine if, and for what amount, coverage should have been in force.

No statement, except fraudulent misstatements made by you relating to your insurability, will be used to contest the insurance for which the statement was made after the insurance has been in force for 2 years during your lifetime. Inorder to be used, the statement must be in writing and signed by you.

All statements made by the policyholder, the employer or you under the policy will be deemed representations andnot warranties. No statement made to affect this insurance will be used in any contest unless it is in writing and a copy of it is given to the person who made it, or to his/her beneficiary or your representative.

How Prior Coverage Affects Coverage Under This Plan

Prior coverage is any plan of group STD coverage providing weekly benefits that has been replaced by coverage under all or part of this plan. It must have been sponsored by DXC. The replacement can be complete or in part for the eligible class to which you belong. Any such plan is prior coverage if provided by another group insurance plan.

If a person's coverage under this plan replaces any prior coverage of that person, the following will apply: The coverage under this plan replaces and supersedes any prior coverage. It will be in exchange for everything under such prior coverage, except that no benefit will be payable under this plan as to a particular period of disability if:

- The covered person is receiving, or eligible to receive, benefits for that disability under the prior coverage; or
- In the absence of coverage under this plan, the covered person would have been eligible to receive benefits for that disability under the prior coverage.

Short-Term Disability Not a Substitute for Workers' Compensation Insurance

The group policy is not in lieu of and does not affect workers' compensation benefits. However, any workers- compensation benefits are considered other income benefits.

Certificate of Insurance

A separate certificate of insurance will not be distributed. You may obtain a copy of the Insurer's certificate of insurance booklet from the DXC Benefits Center portal (myDXCbenefitscenter.com), and such booklet is incorporated herein by reference.

This SPD explains the general purposes of the insurance described. In the event of any discrepancy between the SPD and certificate of insurance booklet, the certificate of insurance booklet applies.

Contacting the Carrier

Contact information for all benefit carriers is provided in the back of this Guidebook.

Section 11

Long-Term Disability Insurance Plan

Long-Term Disability Insurance Plan

General Information, Eligibility, & Enrollment

Introduction

DXC offers Long-Term Disability (LTD) coverage as a voluntary, employee-paid benefit. Contributions are made by employees on a post-tax basis; therefore, any LTD benefits you receive that are attributable to your post-tax contributions are not taxable.

This plan is insured and administered by The Hartford (the Insurer).

With respect to terms used in this section, please refer to the benefit booklet / certificate of coverage provided by the Insurer for a complete list of definitions and applicable terms and conditions.

For convenient reference in this Guidebook, the LTD plan is described as a separate plan. These benefits are provided through a sub-part of the ERISA plan (plan number 502) through which other benefits are provided (such as life insurance and accidental death & dismemberment coverages). See **Section 15, ERISA Information.**

For a list of participating employers for the overall ERISA plan of which this coverage is a part, see **Section 15, ERISA Information**. **Section 15** also shows whether a participating employer offers the LTD plan to its employees. Not all employers offer this coverage. Also, some participating employers only offer this coverage to certain employee groups. See **Section 15, ERISA Information** for more information.

Employee Eligibility

For LTD coverage, you are subject to the same provisions and definitions regarding eligibility as set forth in **Section 2, Medical Plans**. You are eligible to enroll for coverage in the LTD plan on the first day you report to work if you satisfy the applicable eligibility requirements.

If you are enrolled in this plan but are absent from work due to injury or sickness on the day this coverage would normally begin, you will be covered when you report to work on a regular, full-time basis for a period of at least one full day.

Enrollment/Effective Date of Long-Term Disability Coverage

Enrolling in Long-Term Disability Coverage

Employee LTD coverage is an optional benefit plan that requires enrollment. You can enroll yourself in LTD coverage at one of the following times:

- Within 30 days of your hire date (or initial date of eligibility) or by the deadline on your enrollment notice (whichever is later); or
- During the Annual Benefits Open Enrollment period; or
- Within 30 days of a qualified change of status, special enrollment, or a specifically permitted event (all as described in **Section 14, DXC Technology Company Cafeteria Program** under **Changing Your Cafeteria Plan Elections).**

To enroll, access the DXC Benefits Center online (myDXCbenefitscenter.com) or call1.888.305.5499.

The consequences for not enrolling in LTD benefits are as follows:

- If you do not enroll within one of the periods described above, your LTD election will default to waiver of coverage.
- If the annual enrollment period requires active enrollment for the following plan year, and you do not enroll, your LTD election will default to waiver of coverage.

It is your responsibility to review your remuneration statement (paystub) to confirm deductions accurately reflect your elections.

Your election is irrevocable and binding. Your next opportunity to enroll or make enrollment changes will be during the Annual Benefits Open Enrollment period, unless you have a qualified change of status, are eligible for a special enrollment, or have another specifically permitted event as described in **Section 14**, **DXC Technology Company Cafeteria Program** under **Changing Your Cafeteria Plan Elections**. The same provisions also apply to this benefit plan.

Effective Date of Long-Term Disability Coverage

Enrollment Event	Effective Date
New hire/newly eligible	Retroactive to hire date/initial date of eligibility
Annual Benefits Open Enrollment[1]	January 1 of new plan year or retroactive to date Insurer approves EOI (if required) – whichever is later
Qualified change of status, special enrollment, or specifically permitted event[1]	Retroactive to date Insurer approves EOI

1. Evidence of insurability is required if you are enrolling.

Deferred Effective Date Provision

The effective dates above are subject to the deferred effective date provision. If on the date coverage or an increase in coverage would have otherwise been effective, you are absent from work due to any of the reasons below, the effective date of coverage will be deferred until you have returned to active work for one full workday:

- Accidental bodily injury
- Sickness
- Mental illness
- Substance abuse
- Pregnancy

Evidence of Insurability

Evidence of Insurability (EOI) is required for certain enrollment events. Enrollment in LTD coverage will not be effective until the Insurer approves your EOI statement. For coverage that requires EOI, the Insurer may still deny coverage after receipt and review of the required documentation. EOI may include, but is not limited to:

- Completed, signed application
- Medical exam
- Attending physician statement
- Any other information the Insurer may require.

EOI and Long-Term Disability Insurance

EOI requirements for LTD enrollment are shown in the following table:

Enrollment Event	EOI Required?
New hire/newly eligible	No
Annual Benefits Open Enrollment	Yes
Qualified change of status, special enrollment, or specifically permitted event	Yes

Elections requiring EOI will not be effective unless the Insurer approves your application (see **Annual Benefits Open Enrollment Period/Changing Your Elections**). See above under **Effective Date of Long-Term Disability Coverage** for when coverage elections requiring EOI are effective.

Impact of Unsatisfactory EOI

If your EOI is not satisfactory to the Insurer, you will not be covered under the policy for the coverage subject to EOI.

How to Submit EOI

When you enroll in the DXC Benefits Center enrollment portal (myDXCbenefitscenter.com) for coverage requiring EOI, a link to the Insurer's EOI processing website will appear in the enrollment workflow. Please follow the link for instructions on submitting EOI.

Annual Benefits Open Enrollment/Changing Your Elections

Annual Benefits Open Enrollment Period

Once each year, you have an opportunity to change your LTD election. The Annual Benefits Open Enrollment (Annual Enrollment) period is usually held in October/November for an effective date of January 1 of the new plan year. See above under **EOI and Long-Term Disability Insurance**, for changes requiring EOI. See also **Effective Date of Long-Term Disability Coverage**, above, for when coverage elections requiring EOI are effective.

The elections you make during the Annual Enrollment period, including default elections, are irrevocable and binding until the next Annual Enrollment period unless you are eligible to change your elections as described in **Section 14**, under **Changing Your Cafeteria Plan Elections**. The same provisions also apply to this benefit plan.

Unless the company communicates otherwise prior to Annual Enrollment, your LTD coverage will continue each year as previously elected, but at new plan year prices, unless you make a change during the Annual Benefits Open Enrollment period. This must not be interpreted as a promise or guarantee that the same benefit plans will be available to you from one year to the next. (See **Introduction** on **page 11-1**, above.)

Changing Your Elections

See **Section 14, DXC Technology Company Cafeteria Program under Changing Your Cafeteria Plan Elections**. The same provisions also apply to this benefit plan.

Cost of Participation in the Long-Term Disability Plan

You pay the full cost of LTD coverage. The cost of participating in LTD coverage is available on the enrollment site when you are ready to enroll. Contributions under collective bargaining agreements (CBAs) may vary. See your CBA for details, if applicable.

Post-Tax Contribution for Long-Term Disability Coverage

Your contributions for your elected LTD coverage will be taken from your gross salary through payroll deductions after applicable federal income taxes and state income taxes are calculated. However, benefits you receive through the LTD plan that are attributable to your post-tax contributions are not taxable.

Benefits Provided

The benefits provided are summarized below. In the event of a conflict between the benefits described here, and benefits described in the applicable carrier's Certificate of Coverage, the Certificate of Coverage shall control.

Test of Disability

To receive benefits, you must first meet the test of disability. You meet the test of disability if you are not able to perform the material duties of your own occupation because of an illness or injury, or because of a pregnancy-related condition. You are not performing the material duties of your own occupation if:

- You are only performing some of the material duties of your own occupation; and
- Your income is 80% or less of your pre-disability earnings solely because of an illness, injury, or a disabling pregnancy-related condition.

The loss of a professional or occupational license or certification that is required by your own occupation does not mean that you meet the test of disability. You must meet this plan's test of disability, as determined by the Insurer, to be considered disabled.

Long-Term Disability Benefit Period

Once you meet the LTD test of disability described above, your LTD benefits will begin on the next day after you complete the plan's 180-day elimination period. The elimination period is the amount of time you must be disabled before benefits start. No benefit is payable for or during the elimination period. You must be under the care of a physician and provide satisfactory proof of disability to the Insurer.

Your LTD benefits will be payable for as long as your disability benefit eligibility continues, but not beyond the end of the maximum duration of benefits period.

Long-Term Disability Benefits Payable

Basic Benefit

LTD benefit payments are 60% of your monthly pre-disability base earnings (excluding commissions, bonuses, overtime pay, or any other pay or fringe benefits). They are payable on a monthly basis, reduced by income you receive from "other income benefits" as explained below and are subject to a maximum benefit of $15,000 per month.

The minimum monthly benefit is the greater of $100 or 10% of the benefit based on monthly income loss before deduction of other income benefits.

Benefits will be paid at the end of each month during the period for which benefits are payable. Monthly benefits for a period less than a month will be prorated. This will be done on the basis of the ratio to 30 days of the days of eligibility for benefits during the month.

Because you pay for this coverage on a post-tax basis, the benefits you receive through the DXC LTD plan that are attributable to your post-tax contributions are not taxable.

The monthly benefit is based on your pre-disability earnings, up to the maximum monthly benefit shown in the schedule of benefits. To calculate your monthly LTD benefit, multiply:

- Your pre-disability earnings; times
- The monthly benefit percentage of 60%.

The benefit payable will be the lesser of:

- The monthly benefit; and
- The maximum monthly benefit.

Any other income benefits you are eligible for may affect your benefits from this plan. The amount of the other income benefits will be subtracted from your monthly LTD benefits for which you are eligible. Please refer to the **Effect of Other Income on Long-Term Disability Benefits** section of this SPD for details as to which other income benefits may reduce your monthly benefit.

Any change in the amount of coverage due to a change in compensation will not take effect unless and until an employee is at work.

Benefits Under Specific Circumstances

You may be eligible to for LTD benefits under specific circumstances if applicable terms and conditions are satisfied, including but not limited to (i) mental illness and/or substance abuse treatment; (ii) family care credit benefit, (iii) survivor income benefit, (iv) workplace modification benefit, and (v) a rehabilitation bonus. For a complete description of these benefits and the applicable terms and conditions, please refer to your benefit booklet / certificate of coverage provided by the Insurer.

Maximum Duration of Benefits

You will continue to receive LTD benefits for as long as you meet the benefit eligibility requirements or you exhaust the maximum duration of benefits, whichever occurs earlier:

Age When Disabled	Maximum Benefits Payable
Prior to Age 63	To Normal Retirement Age or 42 months, if greater
Age 63	To Normal Retirement Age or 36 months, if greater
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

Normal Retirement Age

For purposes of the maximum duration of benefits described here, ***Normal Retirement Age*** means the Social Security Normal Retirement Age under the most recent amendments to the United States Social Security Act, which is determined by your date of birth as follows:

Year of Birth	Normal Retirement Age
1937 or earlier	65
1938	65 + 2 months
1939	65 + 4 months
1940	65 + 6 months
1941	65 + 8 months
1942	65 + 10 months
1943 through 1954	66
1955	66 + 2 months
1956	66 + 4 months
1957	66 + 6 months
1958	66 + 8 months
1959	66 + 10 months
1960 or later	67

Benefits During Family and Medical Leave (FMLA)

DXC employees on an approved FMLA leave will be required to use all available paid leave (accrued sick and/or flexible vacation) in accordance with established guidelines governing the use of paid leave, see the DXC **U.S. Sick Leave** and **U.S. Flexible Vacation** policies, available on Employee Connect. If you are enrolled in the voluntary LTD plan, you are not required to file a claim and may use paid leave for the entire FMLA covered absence. However, if you decide to file a claim for LTD benefits, you must use sick and/or flexible vacation leave during your elimination period. At the end of the elimination period, the use of sick and/or flexible vacation leave will stop, and any sick and vacation, if applicable, leave you have accrued up to that date will be held in suspense until you return to work.

You are not entitled to use sick and vacation leave in lieu of disability benefits, during the period a claim is being evaluated by the Insurer, while receiving disability benefits, or in conjunction with disability benefits. However, you may use accrued sick and vacation leave in the event a disability claim is denied or discontinued.

DXC paid time off (e.g., sick leave, flexible vacation) may be used during the LTD elimination period and while you are on Family & Medical Leave (FMLA) but may not be used once LTD benefits become payable. LTD benefits will be reduced by any pay received from DXC. Any unused sick leave and vacation will remain available for use upon your return to work.

When Long-Term Disability Benefits End

You will no longer be considered disabled or eligible for monthly benefits when the first of the following occurs:

1. The date you no longer meet the LTD test of disability, as determined by the Insurer
2. The date you fail to furnish proof of loss

3. The date you are no longer under the regular care of a physician
4. The date you refuse to be examined by or cooperate with an independent physician, or a licensed and certified healthcare practitioner, as requested. The Insurer has the right to examine and evaluate you at any reasonable time while your claim is pending or payable. (The examination or evaluation will be done at the Insurer's expense)
5. The last day benefits are payable according to the maximum duration of benefits table
6. The date of your death
7. The date no further benefits are payable under any provision in the policy that limits benefit duration
8. The date your current monthly earnings:
    a. Are equal to or greater than 80% of your indexed pre-disability earnings if you are receiving benefits for being disabled from "Your Occupation" or
    b. Are greater than the lesser of the product of your indexed pre-disability earnings and the benefit percentage or the maximum monthly benefit if you are receiving benefits for being disabled from "Any Occupation"
9. The date you refuse to receive recommended treatment that is generally acknowledged by physicians to cure, correct or limit the disabling condition
10. The date you refuse to participate in a rehabilitation program, or refuse to cooperate with or try:
    a. Modifications made to the work site or job process to accommodate your identified medical limitations to enable you to perform the essential duties of your occupation;
    b. Adaptive equipment or devices designed to accommodate your identified medical limitations to enable you to perform the essential duties of your occupation;
    c. Modifications made to the work site or job process to accommodate your identified medical limitations to enable you to perform the essential duties of any occupation, if you were receiving benefits for being disabled from any occupation; or
    d. Adaptive equipment or devices designed to accommodate Your identified medical limitations to enable you to perform the essential duties of any occupation, if you were receiving benefits for being disabled from any occupation; provided a qualified physician or other qualified medical professional agrees that such modifications, rehabilitation program or adaptive equipment accommodate your medical limitation

Recurrent Disabilities

Periods of Recovery during the elimination period will not interrupt the elimination period, if the number of days you return to work as an active employee are less than 1/2 the number of days of your elimination period. Any day within such period of recovery, will not count toward the elimination period. After the elimination period, if you return to work as an active employee and then become disabled and such disability is:

1. Due to the same cause; or
2. Due to a related cause; and
3. Within 6 months of the return to work.

The period of disability prior to your return to work and the recurrent disability will be considered one period of disability, provided the policy remains in force.

If you return to work as an active employee for 6 months or more, any recurrence of a disability will be treated as a new disability. The new disability is subject to a new elimination period and a new maximum duration of benefits.

Period of Disability means a continuous length of time during which you are disabled under the policy.

Recover or ***Recovery*** means that you are no longer disabled and have returned to work with the employer and premiums are being paid for you.

Effect of Other Income on Long-Term Disability Benefits

Other income and benefits you receive while covered by LTD benefits may impact the amount of STD benefits you receive. Please refer to your benefit booklet / certificate of coverage for details regarding which income affects your LTD benefits and the impact of that income on your LTD benefits.

Exclusions

LTD coverage does not cover any disability that is:

- Not under the regular care of a physician
- Caused by or contributed to by war or any act of war (declared or not declared)
- Caused by or contributed to by an intentional self-inflicted injury (while sane or insane)
- Caused by or contributed to by your commission of, or attempt to commit a criminal act
- Caused by or contributed to by your being engaged in an illegal occupation
- Sustained as a result of doing any work for pay or profit from another employer, including self-employment
- Covered under a prior disability plan sponsored by your employer, which was terminated before this effective date of this policy and for which you are receiving or eligible to receive benefits

Pre-Existing Conditions

No benefits will be paid for any disability that results from or is caused by or contributed to by a pre-existing condition, unless, at the time you become disabled:

- You have not received medical care for the condition for 3 consecutive months while insured under the policy; or
- You have been continuously insured under the policy for 12 consecutive months.

Pre-existing Condition means:

- Any accidental bodily injury, sickness, mental illness, pregnancy, or episode of substance abuse; or
- Any manifestations, symptoms, findings, or aggravations related to or resulting from such accidental bodily injury, sickness, mental illness, pregnancy, or substance abuse; for which you received medical care during the 3 consecutive month(s) period that ends the day before your effective date of coverage; or the day before the effective date of a change in coverage.

Claims & Appeals

For information on how to submit an LTD insurance claim for benefits or appeal a decision related to an LTD insurance claim, please contact the insurance provider directly and reference the providers benefit booklet and certificate of coverage, incorporated herein by reference. The insurance provider is the claims administrator for your LTD benefits. Contact information for your LTD insurance provider is provided in the back of this Guidebook.

Please keep in mind that a claim for LTD benefits is subject to specific deadlines and procedures, all of which are set forth in the carrier's benefit booklet and/or certificate of coverage.

Termination Of Coverage and Continuation Options

Coverage under your plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

Termination of LTD Coverage

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by DXC; or
- Your DXC employment ends for any reason, including job elimination or being placed on severance.

Continuation of LTD Coverage While on Approved Leave of Absence

DXC may extend your LTD coverage while you are on an approved disability leave of absence. You may elect to extend your LTD coverage during the period of approved leave (see **DXC U.S. Leaves of Absence with Pay** and **DXC U.S. Leaves of Absence without Pay** policies and **DXC Leaves of Absence Guide** available in Employee Connect) by paying the full cost of the coverage to the DXC Benefits Center.

Personal Leave of Absence

If you are on a documented leave of absence, other than Family & Medical Leave Act (FMLA) or Military Leave, your coverage may be continued for 12 month(s) after the month in which the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Military Leave of Absence

If you enter active full-time military service and are granted a military leave of absence in writing, your coverage (including LTD coverage) may be continued for up to 12 months after the month in which the leave of absence commenced if you pay the full cost of coverage. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Family and Medical Leave (FMLA) and Medical Leave

If you are granted a leave of absence, in writing, pursuant to the Family and Medical Leave Act of 1993, other applicable state or local law, or DXC Medical Leave policy, your coverage(s) (including LTD coverage) may be continued for the duration of the Family Medical Leave or up to one calendar year from the effective date of the Medical Leave (whichever is shorter). If the leave of absence ends prior to the agreed upon date, this continuation will cease immediately.

Leave Due to Disability

If you are disabled, your LTD coverage will be continued:

- While you remain disabled; and
- Until the end of the period for which you are entitled to receive LTD benefits, provided you continue to pay premiums.

After your LTD payments have ceased, your insurance will be reinstated provided you:

- Return to work for one full day as a full-time active employee in an eligible class;
- The policy remains in force; and
- The premiums were paid during your disability and continue to be paid.

Extension of Long-Term Disability Coverage and Benefits

If you are entitled to LTD benefits while disabled and the policy terminates, benefits:

- Will continue as long as you remain disabled by the same disability; and
- Will not be provided beyond the date the Insurer would have ceased to pay benefits had the policy remained in force.

General Terms Applicable to Long-Term Disability

Overpayment

Definition of Overpayment

An overpayment occurs:

- When the Insurer determines that the total amount it has paid in benefits is more than the amount that was due to you under the policy; or
- When payment is made by the Insurer that should have been made under another group policy.

This includes, but is not limited to, overpayments resulting from:

- Retroactive awards received from sources listed in the Other Income Benefits that Reduce Monthly Long- Term Disability Benefits section, above;
- Failure to report, or late notification to the Insurer of any earned income or income listed in **Other Income Benefits that Reduce Monthly Long-Term Disability Benefits**;
- Misstatement;
- Fraud; or
- Any error by the Insurer.

Recovery of Overpayment

The Insurer has the right to recover from you any amount that it determines to be an overpayment. You have the obligation to refund any such amount to the Insurer. The Insurer's right and your obligations in this regard may also be set forth in the reimbursement agreement you will be required to sign when you become eligible for benefits under the policy.

If benefits are overpaid on any claim, you must reimburse the Insurer within 30 days. If reimbursement is not made in a timely manner, the Insurer has the right to:

1. Recover such overpayments from:
   a. You;
   b. Any other organization;
   c. Any other insurance company;
   d. Any other person to or for whom payment was made; and
   e. Your estate;
2. Reduce or offset against any future benefits payable to you or your survivors, until full reimbursement is made; payments may resume when the overpayment has been recovered;
3. Refer your unpaid balance to a collection agency; and
4. Pursue and enforce all legal and equitable rights in court.

Subrogation

The Insurer will be subrogated to any rights you may have against a third party if:

- You suffer a disability because of the act or omission of a third party; and
- Become entitled to and are paid benefits under the policy; and
- Do not initiate legal action for the recovery of such benefits from the third party within a reasonable period of time.

Accordingly, the Insurer may, at its option, bring legal action against the third party to recover any payments the Insurer has made in connection with the disability.

“Third party” as used in this provision, means any person or legal entity whose act or omission, in full or in part, causes you to suffer a disability for which benefits are paid or payable under the policy.

Reimbursement

The Insurer has the right to request reimbursement for any benefit payments made or required to be made under the policy for a disability for which you recover payment from a third party. If you recover payment from a third party as the result of:

- A legal judgment;
- An arbitration award; or
- A settlement or otherwise;

Then you must reimburse the Insurer for the lesser of the:

- Amount of payment made or required to be made by the Insurer; or
- Amount recovered from the third party less any reasonable legal fees associated with the recovery.

“Third party” as used in this provision, means any person or legal entity whose act or omission, in full or in part, causes you to suffer a disability for which benefits are paid or payable under the policy.

Policy Interpretation

The Insurer has full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the policy. This provision applies where the interpretation of the policy is governed by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Legal Actions

Legal action cannot be taken against the Insurer:

- Earlier than 60 days after the date written proof of loss is furnished; or
- More than 3 years after the date proof of loss was required to be furnished according to the terms of the policy.

Fraud

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may have violated state law.

Misstatements

If material facts about you or your dependents were not stated accurately:

- The premium may be adjusted; and
- The true facts will be used to determine if, and for what amount, coverage should have been in force.

No statement, except fraudulent misstatements, made by you relating to your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for 2 years during your lifetime. In order to be used, the statement must be in writing and signed by you.

All statements made by the policyholder, the employer, or you under the policy will be deemed representations and not warranties. No statement made to affect this insurance will be used in any contest unless it is in writing and a copy of it is given to the person who made it, or to his/her beneficiary or your representative.

How Prior Coverage Affects Coverage Under This Plan

“Prior coverage” is any plan of group LTD coverage providing monthly benefits that has been replaced by coverage under all or part of this plan. It must have been sponsored by DXC. The replacement can be complete or in part for the eligible class to which you belong. Any such plan is prior coverage if provided by another group insurance plan.

If a person’s coverage under this plan replaces any prior coverage of that person, the following will apply: The coverage under this plan replaces and supersedes any prior coverage. It will be in exchange for everything under such prior coverage, except that no benefit will be payable under this plan as to a particular period of disability if:

- The covered person is receiving, or eligible to receive, benefits for that disability under the prior coverage; or
- In the absence of coverage under this plan, the covered person would have been eligible to receive benefits for that disability under the prior coverage.

Long-Term Disability Not a Substitute for Workers’ Compensation Insurance

The group policy is not in lieu of, and does not affect, workers’ compensation benefits. However, any workers- compensation benefits are considered other income benefits.

Certificate of Insurance

A separate certificate of insurance will not be distributed. You may obtain a copy of the Insurer’s certificate of insurance booklet from the DXC Benefits Center portal (myDXCbenefitscenter.com), and such booklet is incorporated herein by reference.

This Guidebook explains the general purposes of the insurance described. **In the event of any discrepancy between the Guidebook and certificate of insurance booklet, the certificate of insurance booklet applies.**

Contacting the Carrier

Contact information for all benefit carriers is provided in the back of this Guidebook.

Section 12

Commuter Reimbursement Account

Commuter Reimbursement Account

General Information, Eligibility, & Enrollment

Introduction

DXC offers a Commuter Reimbursement Account (Commuter Plan) plan as a voluntary, employee-paid benefit. The Commuter plan is an IRS Section 132(f) transportation plan that allows you to use pre-tax dollars to pay for qualified expenses related to your work commute.

This plan is administered by MetLife.

Employee Eligibility

For convenient reference in this Guidebook, the Commuter Plan is described as a separate plan. These benefits are provided through a sub-part of the ERISA plan (plan number 501) through which other benefits are provided (such as the DXC Technology Company Cafeteria Program). See **Section 15, ERISA Information.**

For a list of participating employers in the ERISA plan of which this coverage is a part, see **Section 15, ERISA Information**. **Section 15** also shows whether a participating employer offers the Commuter Plan to its employees. Not all employers offer this coverage. Also, some participating employers only offer this coverage to certain employee groups. See **Section 15, ERISA Information** for more information.

You are eligible to participate in the Commuter plan on the first day you report to work if you:

1. Are on a U.S. payroll, and
2. Work in the U.S., and
3. Work for an employer that offers this benefit to its employees (see **Section 15, ERISA Information**), and
4. Either:
    a. Are a regular full-time or limited-term full-time employee not covered under a collective bargaining agreement (CBA), unless the agreement specifically includes participation in this plan's features; or
    b. Are covered by a local ordinance (e.g., the San Francisco Commuter Benefits Ordinance) that requires your employer to offer commuter benefit similar to DXC's Commuter plan.

If you are enrolled in this Commuter Plan but are absent from work due to injury or sickness on the day this coverage would normally begin, you will be covered when you report to work on a regular, full-time basis for a period of at least one full day.

The following employees are not eligible:

- Temporary employees
- Part-time employees (regular and limited-term) except those covered under 4b, above
- Casual employees
- Employees working outside of the U.S. (including those working in U.S. Territories)
- Employees working in the U.S. while also receiving all or part of their base pay from a non-U.S. payroll

Refer to the **DXC U.S. Employment Classification Policy** (available on Employee Connect) for definitions of the various employment classifications, which are also listed in **Section 1, Introduction and Eligibility**. The same provisions apply to this benefit plan.

Enrollment

When You Can Enroll

You can elect to enroll in the Commuter plan at any time and for any duration. You can participate for one month at a time or set up a recurring monthly order or contribution.

How to Enroll

You can enroll in the Commuter plan on the *Your Spending Account* (YSA) site, found on the DXC Benefits Center enrollment portal (myDXCbenefitscenter.com).

Changing Your Elections

You may change your election during the plan year; however, the election is irrevocable for the duration of the one-month coverage period to which it relates.

Benefits Provided

Important: This subsection is intended to provide a general discussion to facilitate your understanding of the limits and restrictions associated with using money from your Commuter plan account. It is not intended to provide you with personal tax or financial planning advice. Neither DXC nor the plan and claims administrator will be held responsible for any use/misuse of the information provided in this section when making personal tax or financial planning decisions in connection with the preparation of your personal income tax return.

The Commuter plan allows you to use pre-tax dollars to pay for qualified expenses related to your commute. You are accountable for ensuring that you are using the funds for qualified expenses only. The 2023 pre-tax contribution limits are:

- $300 per month for mass transit; and
- $300 per month for commuter parking

Contributions are deducted from your pay on a pre-tax basis before federal and state income taxes, where permitted.

Tolls are not considered qualified commuting expenses. Note also that the DXC plan does not offer benefits for expenses related to commuting by bicycle.

The deadline for your orders and elections is the 10th of each month for the following month. For example, you need to place your order by January 10th for use in February.

For more information on IRS rules regarding qualified commuting expenses, see IRS Publication 15-B, “Employer’s Tax Guide to Fringe Benefits,” available on the IRS website (http://www.irs.gov/pub/irs-pdf/p15b.pdf) or by calling 1.800.829.1040.

Mass Transit Benefit

Mass transit expenses are defined as those for bus, subway, train, metro, ferry, and van pooling. A van pool is defined as a licensed commuter highway vehicle with seating capacity for six or more adults, excluding the driver.

To use the mass transit benefit, order your transit ticket, pass, or voucher via the YSA site (myDXCbenefits.com). YSA offers an extensive network of transit services throughout the U.S. Once you have placed your order, the product will be mailed to your home. The cost will be deducted from your pay

before federal and state taxes (where allowed). If the cost of your product exceeds the monthly pre-tax contribution limit, the excess amount will be deducted from your pay on a post-tax basis.

Commuter Parking Benefit

The parking benefit can be used to pay for parking on or near your regular work site (that is not your home) or near a location from which you commute to work using mass transit. There are two ways to use the parking benefit: Pre-Order and Cash Reimbursement.

Pre-Order: You can order parking passes and vouchers directly through the YSA site. Once you place your order, your product will be mailed to your home. The cost will be deducted from your pay before federal and state taxes (where allowed). If the cost of your product exceeds the monthly pre-tax contribution limit, the excess amount will be deducted from your pay on a post-tax basis.

Cash Reimbursement: If your parking provider does not accept parking vouchers or participate in YSA's network, you can elect to set aside money from your pay on a pre-tax basis to reimburse yourself for qualified parking expenses. Simply make your election on the YSA site and that amount will be deducted from your pay. You can then submit your parking receipts to YSA for reimbursement. You will be reimbursed up to the monthly pre-tax contribution limit. Money you set aside for the parking benefit can only be used for parking-related expenses; it cannot be applied to mass transit benefits.

Any money you do not use will roll over in your Commuter plan account from month to month. Note that the pre-tax contribution limit on parking expenses is a cap both on your pre-tax deductions for parking and on your monthly reimbursement. For example, if you have $280 deducted from your pay for January and also for February commuting months, but only request $100 in parking expense reimbursement for January, your available balance will be $430; however, you would only be able to claim up to $265 in parking expenses for February.

Parking reimbursement receipts must be submitted no more than 180 days from the date the expense was incurred, but no later than March 31 following the end of the plan year.

Conditions Under Which Coverage Terminates

Your participation in the DXC Commuter plan ends on the earlier of the following dates:

- Your employment with DXC ends
- You no longer meet the definition of an eligible employee
- The plan ends

Also see **Section 14, DXC Technology Company Cafeteria Program**, **Period of Coverage**. The same provisions also apply to this benefit plan. IRS regulations do not allow you to continue participating in the Section 132(f) Tax- Free Transportation Plan through the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Any remaining funds in your Commuter plan account are forfeited upon termination. The deadline for submitting claims for the Parking Reimbursement benefit is 180 days from the date the expense is incurred, but no later than March 31 following the end of the plan year.

Contacting the Administrator

Contact information for all benefit carriers and administrators is provided in the back of this Guidebook.

Section 13

Health Reimbursement Account

Health Reimbursement Account

General Information, Eligibility, & Enrollment

Introduction

DXC offers a Health Reimbursement Account (HRA) — also known as a Health Reimbursement Arrangement — as a voluntary employer-funded account in conjunction with the Healthy Behaviors Wellness Program. The HRA allows DXC to provide you with any incentives you earn through the Healthy Behaviors Wellness Program on a pre-tax basis, as long as you use those funds for qualified medical, dental, or vision expenses.

While most employees will elect to have their wellness incentives credited to a DXC Health Savings Account (HSA) the HRA is an alternative funding mechanism when:

- You are not eligible for a DXC HSA; or
- You have not opened a DXC HSA at the time you earn wellness incentives.

This plan is administered by MetLife.

Eligibility

For convenient reference in this Guidebook, the DXC HRA plan is described as a separate plan. These benefits are provided through a sub-part of the ERISA plan (plan number 501) through which other benefits are offered (such as the DXC Commuter Reimbursement Account Plan, and the DXC Technology Company Cafeteria Program). See **Section 15, ERISA Information**.

For a list of participating employers in the ERISA plan of which this coverage is a part, see **Section 15, ERISA Information**. **Section 15** also shows whether a participating employer offers the HRA to its employees. Not all employers offer this coverage. Also, some participating employers only offer this coverage to certain employee groups. See **Section 15, ERISA Information** for more information.

You are eligible to participate in an HRA if:

- You are eligible for, and enrolled in, a DXC high deductible health plan (i.e., Bronze, Bronze Plus, or Silver medical plan options);
- You have enrolled in the DXC Healthy Behaviors Wellness Program; and
- You are not enrolled in a DXC HSA for the current Plan year.

See **Section 2, DXC Medical Plans**, above.

Enrollment

You do not need to actively enroll in an HRA. **An HRA will be automatically established for you** if the following conditions apply:

- You meet the eligibility requirements, above; and
- You earn incentives through the DXC Healthy Behaviors Wellness Program.

Once enrolled, you will receive information directly from MetLife.

Changing Your Elections

Once you are enrolled in an HRA during the plan year, per IRS rules, you cannot subsequently open an HSA. If you have a qualified change in status (See **Section 14**, **DXC Technology Company Cafeteria Program**), and subsequently enroll in a Health FSA, any claims will be drawn against your HRA balance before being drawn against your FSA balance.

Benefits

Eligible HRA Expenses

Important: This subsection is intended to provide a general discussion to facilitate your understanding of the limits and restrictions associated with using money from your HRA. It is not intended to provide you with personal tax or financial planning advice. Neither DXC, Computer Sciences Corporation, the ERISA plan, nor the claims administrator will be held responsible for any use/misuse of the information provided in this section when making personal tax or financial planning decisions in connection with the preparation of your personal income tax return.

You can use your HRA to reimburse yourself for eligible expenses not covered by any other healthcare plan. Eligible expenses include those expenses for medical care, within the meaning of Section 213(d) of the Internal Revenue Code, incurred by you and/or any Eligible Dependents (see **Section 14**, **DXC Technology Company Cafeteria Program**, under **Special Definitions Regarding Dependents**), and which have not already been reimbursed.

To use your HRA funds to pay for a medical expense, the expense must be incurred during the participant's period of coverage under the HRA (i.e., after the HRA has been established). Expenses are treated as having been incurred when the participant is provided with the medical care that gives rise to the medical expense, and not when the participant is formally billed or charged for, or pays for the medical care. Also, expenses are not treated as incurred during a period of coverage if those expenses are incurred before the date the participant first becomes enrolled under the HRA. The plan also cannot make advance reimbursement of future or expected expenses.

Some of the eligible medical expenses (as set forth in Internal Revenue Code Section 213) currently include:

- Healthcare plan deductibles and copayments including excess of reasonable and customary or recognized limits and plan annual or lifetime limits
- Chiropractors
- Communication equipment for the deaf
- Coverage continuation (COBRA) premiums
- Dentures
- Feminine care products
- Healthcare insurance premiums while receiving unemployment compensation
- Hearing aids and exams
- In vitro fertilization
- Long-term care insurance premiums
- Medical equipment rental
- Orthodonture (braces)
- Orthopedic shoes
- Prescription drugs
- Prescription eyeglasses/contact lenses
- Psychiatrist/psychologist fees

- Routine physicals including immunizations and well-baby care
- Speech therapy and learning disability counseling
- Wheelchairs
- Weight loss programs and/or weight loss drugs, if prescribed by a physician to control a disease
- Eligible over-the-counter medical supplies, such as bandages and contact lens solution
- Eligible over-the-counter drugs, such as pain relievers, heartburn medications, allergy relief

For more information on qualified medical, dental and vision expenses, see IRS Publication 502, *Medical and Dental Expenses*. Please also visit the MetLife website, which you can access via the DXC Benefits Center portal (myDXCbenefitscenter.com)

Submitting Claims

You can use your HRA funds to pay for your qualified medical expenses in two ways: 1) debit card or 2) requesting reimbursement.

Debit Card

You will receive a debit card which you can use to pay providers directly for your qualified medical expenses. Most medical providers can accept the HRA debit card, and using the debit card can generally accelerate claims processing. See below under **Documentation Requirements for Claims**. You must be actively employed by DXC to use your MetLife card. Your card will be deactivated if you leave the company for any reason.

Requesting Reimbursement

If you do not use the debit card, you can submit your receipts and any other required documentation to MetLife and be reimbursed using funds from your account balance. You can access the MetLife website via the DXC Benefits Center portal at myDXCbenefitscenter.com. The MetLife website offers you the convenience of creating a claim form online. Follow the instructions to submit your claims and documentation for processing. You can upload your documentation for eligible expenses directly to the MetLife website. Once your complete claim is received, it will be processed within 5 to 10 calendar days and reimbursement sent directly to you either by bank transfer (recommended) or check. You will be reimbursed from the funds currently available in your account.

Documentation Requirements for Claims

To process all claims, MetLife requires a receipt and may require additional documentation, such as a prescription or statement of medical necessity. If documentation is required for your claim, you will have 30 days from the time of claims submission to send the required documentation to MetLife.

Debit Card Transactions and Documentation

Most debit card claims can be processed automatically. If you use your debit card at an IIAS-certified business, MetLife will attempt to auto-substantiate and pay your claim based on the information collected and transmitted by the merchant. However, if the transaction includes items that are not qualified medical expenses or that require a statement of medical necessity, MetLife will require that you submit additional documentation within 30 days. If the transaction is not conducted at an IIAS-certified business, you will also be required to submit a receipt in accordance with the requirements below. If you do not submit the required documentation by the deadline, the claim will be denied and your account will be placed in overpayment status (see below under **Overpayment**).

Basic Documentation Requirement: The Valid Receipt

To be reimbursed for claims as quickly as possible, you need to submit to MetLife your itemized receipts or other documentation to prove that expenses are eligible under the plan. Generally, the receipt must contain the following information:

1. Name of service provider or retailer
2. Date of service or purchase
3. Identity of drug or product, or description of service
4. Purchase amount for each product or service
5. Total purchase amount

If you've lost the itemized receipt, contact your service provider or pharmacy to request a copy, or call your health plan for an explanation of benefits (EOB). With all claims, you also need to submit to MetLife a completed and signed MetLife claim form, which you can create on the MetLife website.

There may be different or additional documentation requirements depending on the nature of the service for which you are seeking reimbursement.

Medical Services Documentation Requirements

Receipts: You need to provide itemized receipts that contain all of the information in "the Valid Receipt" section above and also the patient's name. The patient's name, however, isn't required for over-the-counter items. If the medical receipt is handwritten, it must include the service provides signature. For prescription drugs, provide the receipt that the pharmacist attached to the prescription rather than the cash register receipt.

Explanation of Benefits (EOB): If you have medical insurance, proof of any amount paid by other coverage, such as an EOB, is necessary. However, an EOB isn't required for:

- Prescriptions
- Vision or hearing expenses
- Receipts that state the amount is for a copayment

Healthcare Supplies: Healthcare supplies are considered eligible expenses and do not require a prescription unless they are considered "dual purpose." See below, under Dual Purpose Items & Statement of Medical Necessity.

Medical Necessity: Some expenses, such as vitamins, are eligible only if they are medically necessary. In those cases, a statement of medical necessity is required. The expense must be an eligible expense in the plan, or it won't be approved even if a doctor provides a statement of medical necessity. A statement of medical necessity is any document that indicates the doctor's name and signature, such as a prescription pad, letter, or preprinted form, and the medical reason or condition for the expense.

Dual Purpose Items & Statement of Medical Necessity: When a healthcare service or product can be used for both medical and general health reasons, it is referred to as "dual purpose." For these items, you must provide additional information to confirm the expense is medically necessary. Some examples of items considered dual purpose are:

- Automobile modifications
- Braille books and magazines
- Cosmetic surgery
- Dental implants
- Exercise equipment
- Humidifiers

- Lodging
- Massage therapy
- Mattresses
- Prescribed food
- Sunglasses
- Support hose
- Tutoring
- Umbilical cord storage
- Vacuums
- Weight loss programs
- Wigs

The ***Statement of Medical Necessity Form*** was created to capture all required information needed to prove a product or service is medically necessary. The form is available on the MetLife website. The following information is required:

1. Patient name
2. Specific diagnosis, diagnosis code (ICD-9), or medical condition
3. Specific length of treatment (including a begin and end date)
4. Name of particular product or service being prescribed
5. Medical provider's signature
6. Date (must be in the current calendar year)
7. Statement that the product or service is medically necessary and not for general health or cosmetic purposes

If you choose to have your provider write a letter, it must be on the provider's letterhead and include the information provided above.

Dental Services Documentation Requirements

You need to provide itemized receipts that contain all of the information in "the valid receipt" section above and also the patient's name. If you have dental insurance, submit your claims to that plan before submitting them to MetLife. If your receipt indicates you have dental insurance, proof of any amount paid by other coverage, such as an EOB, is necessary.

Orthodontia Services Documentation Requirements

You need to provide the following on an itemized bill that includes:

- Name of service provider
- Name of patient
- Date of service provided
- Amount being claimed
- Proof of any amount paid by other dental coverage, such as an EOB, if you have dental insurance

When Paying in Installments: If you're paying in installments, you need to submit a claim and your receipt or payment coupon for each installment. You may be reimbursed:

- Monthly;
- After each installment; or
- In a one-time payment

Travel Expenses Documentation Requirements

You‘re required to provide the following:

- MetLife claim form, on which you identify yourself as the provider
- A receipt with the following information:
  - Travel provider (e.g., taxi service or airline)
  - Date of travel
  - Type of expense (e.g., tolls, parking, or lodging)
- Amount
- Mileage documentation, including one of the following:
  - Printout from a map or website indicating the travel distance
  - Mileage log in which you document your travel date, distance, and destination
- For expenses of $100 or more, a statement of medical necessity is required from a doctor documenting the medical condition for which you‘re receiving care.

Documentation Requirements for Expenses Incurred Outside the United States

To submit a claim for services received or products purchased outside of the United States, provide:

- Receipts and other documentation in English
- Expenses in U.S. dollars

If receipts and documentation are in another language besides English, they must be translated. You, the provider, or someone else can do the translation. The translation can appear on the receipts and documentation, or in a separate document. If you‘re unable to convert the expenses to U.S. dollars from another currency, submit them and MetLife will convert the amounts to dollars.

Claims & Appeals

The claims administrator for all claims arising from the 2023 plan year will be Smart-Choice, and all 2023 claims must be submitted via Smart-Choice by March 31, 2024. The claims administrator for 2024 will be MetLife, so all 2024 claims must be submitted via MetLife.

Deadline for Submitting Claims

The deadline for submitting claims for qualified expenses incurred during the plan year is March 31 of the following plan year. For example, the deadline for submitting claims for expenses incurred during the 2024 plan year is March 31, 2025. Claims submitted after that date will not be processed.

Denial of Claim

If a claim for benefits is wholly or partly denied, you will be furnished with written notification of the decision. This written notification will:

1. State the specific reason(s) for the denial;
2. Make specific reference to the provisions upon which the denial is based;
3. Provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4. Provide an explanation of the review procedure.

Appeal of Claim

On any claim you may appeal to DXC for a full and fair review. To do so, you:

1. Must request a review upon written application within 180 days of the date you were notified of the denial of your claim; and
2. May request copies of all documents, records, and other information relevant to the claim; and
3. May submit written comments, documents, records and other information relating to the claim. To file an appeal, please contact the DXC Benefits Center at 1.888.305.5499.

Overpayment

An overpayment can occur when information that's necessary to prove that an expense was eligible, such as a receipt, isn't provided or adequate. Overpayments can also result from an expense that shouldn't have been paid by MetLife. The most common reasons for an overpayment are:

- A claim that was paid initially but later determined to be ineligible (e.g., using your debit card at a non-IIAS merchant and not submitting receipts; or using your debit card to purchase an ineligible item, or to purchase a dual-purpose item for which you did not submit supporting documentation)
- Changes made to your goal amount due to a qualified change in status, most commonly when you leave the company

Impact of an Overpayment

If your account has an overpayment amount over $100, your MetLife debit card will be suspended until the overpayment is repaid. While you're unable to use your card, you may submit claims on the MetLife site, via fax, through the U.S. Postal Service, or using the mobile app. IRS rules state that failure to resolve your overpayment before the end of the plan year can result in tax implications.

Here are some suggestions to keep in mind when using your MetLife debit card:

- Always save your itemized receipts! You may need them if MetLife notifies you to provide documentation for your transaction
- Send receipts or other documentation for your transaction by the due date
- Review eligible healthcare expenses on this site to become familiar with items and services for which you can use your card
- Don't use your MetLife card to pay for ineligible healthcare items.
- Consider shopping at IIAS-certified merchants, where items are automatically identified as eligible or ineligible at checkout

Errors

Every attempt is made to ensure the accuracy of your claim. If you notice an error, however, you have rights under regulations that govern debit cards. Contact MetLife as soon as possible. You must notify MetLife within 60 days of the process date on your claim. Be prepared to provide the following information:

- Your name and Social Security number
- A description of the error, along with an explanation of why you believe there is an error or why you need more information
- The dollar amount of the suspected error

Unused Balance

If you have funds remaining in your HRA at the end of the plan year, your balance will roll over into the next plan year. However, use of the funds could be limited by your plan elections for the new plan year. For example, you cannot enroll in an HSA if you are enrolled in an HRA. Keep the following in mind if you have an HRA balance remaining at the end of the plan year:

- If you enroll in a DXC HSA for the following plan year, your rolled-over HRA will convert to a “limited purpose” HRA. A limited purpose HRA allows you to use the HRA funds for limited expenses, such as dental and vision only.
- If you enroll in a DXC Health FSA for the following plan year, funds will be drawn first from your HRA balance before being drawn from your FSA to reimburse you for any claims you submit

Contacting the Administrator

Contact information for all benefit carriers and administrators is provided in the back of this Guidebook.

Termination Of Coverage

Conditions Under Which Coverage Terminates

Your participation in the DXC HRA ends on the earlier of the following dates:

- Your employment with DXC ends;
- You no longer meet the definition of an eligible employee; or
- The plan ends.

Upon termination, your MetLife debit card will no longer be active and any remaining funds in your HRA will be forfeited. You will have until March 31 following the end of the plan year to submit claims for expenses incurred prior to your termination date.

Continuation of Coverage

If you are eligible for HRA benefits at the time of termination of employment with DXC, you may be eligible to continue coverage as authorized under **Section 6, COBRA Rights**. The same provisions apply to this benefit plan.

Section 14

DXC Technology Company Cafeteria Program

DXC Technology Company Cafeteria Program

Introduction And Eligibility

DXC's Cafeteria Program allows you to select from a variety of qualified benefits and save for certain expenses on a tax-favored basis. The program is operated in accordance with federal tax laws and includes the following components and features:

- **Pre-Tax Contributions:** The pre-tax contributions component of the program allows you to pay your share of the cost for medical, dental, vision, Supplemental Life, and/or Supplemental Accidental Death and Dismemberment (AD&D) coverage on a pre-tax basis
- **Health Savings Account (HSA):** The HSA component of the program allows you to save for certain current and future medical expenses on a pre-tax basis, provided you participate in a DXC-sponsored high-deductible health plan (i.e., Bronze, Bronze Plus, and Silver medical plan options) and meet the plan eligibility requirements
- **Flexible Spending Accounts (FSAs):**
  - **Health Flexible Spending Account (Health FSA):** The Health FSA component of the program allows you to set aside a portion of your pay on a pre-tax basis to cover certain healthcare (i.e., medical, dental, and vision) expenses you incur during the year
  - **Limited Purpose Health FSA (LPFSA):** The Limited Purpose Health FSA component of the program allows you to set aside a portion of your pay on a pre-tax basis to cover certain dental and vision expenses you incur during the year. Because it can only be used to pay for eligible dental and vision expenses, the LPFSA does not make you ineligible to enroll in an HSA.
  - **Dependent Care Flexible Spending Account (Dependent Care FSA):** The Dependent Care FSA component of the program allows you to set aside a portion of your pay on a pre-tax basis to cover certain dependent care expenses (e.g., day care for dependents to allow you and your spouse, if applicable, to work) you incur during the year

If you elect to participate in one or more components/features of the Cafeteria Program, and you make pre-tax contributions, your contributions will be deducted from your gross salary through payroll deductions before federal income taxes are calculated and before state income taxes are calculated (in states where legally permitted). Your pre-tax contributions effectively lower your federal and (in most states) state income taxes, as well as Social Security and Medicare taxes. Please consult your tax advisor regarding your specific situation.

Eligibility

You are eligible to participate in the Cafeteria Program on the first day you report to work if you:

- Are on a U.S. payroll;
- Work for an employer that offers this benefit to its employees; and
- Are a regular, full-time employee or a limited-term full-time employee, and are not covered under a collective bargaining agreement (CBA), unless the agreement specifically provides for your participation in the plan.

Some employers do not offer the Cafeteria Program, while other employers offer only certain components the program or offer the program only to certain employee groups. For a list of participating DXC subsidiaries and employee groups for the Cafeteria Program, see **Section 15, ERISA Information**.

Note: Please see the appropriate Section in this Guidebook for each component benefit plan included in the Cafeteria Program (as listed above) to determine eligibility for that specific benefit. Eligibility for the Cafeteria Program does not automatically equate to eligibility for each component benefit plan.

Employees residing in Puerto Rico are only eligible to participate in the Pre-Tax Contribution component of the Cafeteria Program.

The following employees are not eligible to participate in the Cafeteria Program:

- Temporary employees
- Part-time employees
- Casual employees
- Employees working in the U.S. who receive all or part of their base pay through a non-U.S. payroll

Refer to **Section 1, Employment Classifications**, for applicable definitions or HRMP 204, Employment Classifications, for additional information. The same provisions apply to the Cafeteria Program.

Special Definitions Regarding Dependents

Throughout this section of the Guidebook, we'll refer to your **DXC Technology Company Cafeteria Program Eligible Dependents** ("Eligible Dependents"); however, please keep in mind that an Eligible Dependent for purposes of this section does not necessarily equate to eligibility for your dependents under other sections of this Guidebook. For each different type of benefit, please see the applicable section in this Guidebook to determine whether your dependents qualify for coverage under that benefit.

To be considered an Eligible Dependent under this section, a person must be your spouse (as recognized by federal law) or your dependent for federal tax purposes as determined in accordance with Section 152 of the Internal Revenue Code (the Code). (See **IRS Publication 17**, **Your Federal Income Tax** for details on who qualifies as your dependent for federal tax purposes.)

NOTE: Regardless of whether your dependent qualifies as an Eligible Dependent under this section, the Cafeteria Program provisions relating to Changing Your Cafeteria Plan Elections, which include changing benefit elections, apply. See below, **Changing Elections for Dependents Who Are Not Cafeteria Program Eligible.** See also, **Changing Your Cafeteria Plan Elections**.

Pre-Tax Contributions

The Pre-Tax Contribution component of the Cafeteria Program permits employees to pay for the cost of medical, dental, vision, Supplemental Life, and/or Supplemental AD&D coverage on a pre-tax basis. Pre-tax contributions are permitted only for the cost of covering you and your Eligible Dependents.

Under existing federal tax laws, coverage for eligible family members who are **NOT** Eligible Dependents must be provided on a post-tax basis outside of the Cafeteria Program. Only Eligible Dependents may be covered under the Cafeteria Program.

See **Changing Your Cafeteria Program Elections,** below, for a description of the rules that apply.

Health Savings Account

Introduction, Eligibility, and General Information

The Health Savings Account (HSA) component of the Cafeteria Program is regulated by Internal Revenue Code Section 223, and is available for reimbursing qualifying healthcare expenses for you and your Eligible Dependents on a pre-tax basis, and non-qualifying healthcare expenses on a taxable basis.

For more information on HSAs, see IRS Publication 969 "*Health Savings Accounts and Other Tax-Favored Health Plans*," which is available on the Internal Revenue Service website (www.irs.gov/pub969) or by calling 1.800.829.1040.

To be eligible to open an HSA and to receive employer contributions to and/or make contributions to an HSA, you must meet all of the following requirements:

- Be enrolled in a DXC-sponsored high deductible health plan (i.e., Bronze, Bronze Plus, and Silver medical plan options); and
- Not be eligible to be claimed as another person's tax dependent, regardless of whether you are actually claimed as a dependent; and
- Not be enrolled in any Medicare coverage; and
- Not have any health coverage, this includes a spouse's general purpose Heath Flexible Spending Account, other than the DXC high deductible health plan in which you are enrolled (except for certain limited types of health coverage, as discussed below)

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)

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

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

HSA Contributions and Limits

Basic Contributions

You may elect to make pre-tax payroll contributions to the HSA during Annual Benefits Open Enrollment or at any time during the plan year through the DXC Benefits Center enrollment portal (myDXCbenefitscenter.com). The total contributions (including company contributions earned through the DXC Healthy Behaviors Wellness Program; see **Company Contributions to Your HSA** below) that can be made to your HSA in any one year are limited by law. The 2024 HSA contribution legal limits depend on your level of coverage:

- $4,150 for eligible participants covering themselves only
- $8,300 for eligible participants covering themselves and one or more dependents

These contribution limits are adjusted annually for inflation. Note that these limits apply only to annual contributions, and not your total account balance. There is no limit on the balance you can maintain in your HSA account.

Contribution Election Changes to Your HSA

You may change or revoke your HSA contribution election at any time during the year on a prospective basis. That is, you can start, increase, decrease, or stop the contributions you make to your HSA at any time during the year, but your election change will be effective only for future payroll periods.

Partial-Year Enrollment and Contributions to Your HSA

Generally, the amount you are permitted to contribute to an HSA depends on the number of months in which you satisfy the eligibility requirements for HSA participation.

Loss of Eligibility: If you lose eligibility for an HSA in the middle of a year, the maximum permitted contribution for that year will be prorated based on the number of months you were eligible during that year. For example, if you are enrolled for Employee Only coverage in a DXC-sponsored high deductible health plan on January 1, 2024, and effective July 1, 2024, you switch to your spouse's health plan, which is not a high deductible health plan, then you will only be eligible to make six months' worth of HSA contributions for 2024 (i.e., 6/12 x $4,150 = $2,075).

Gain of Eligibility: If you become eligible for an HSA in the middle of the year, you are permitted to contribute a full year's worth of HSA contributions as long as:

- You are eligible to contribute to an HSA on December 1 of that year, and
- You remain eligible to contribute to an HSA through the end of the following year

For example, if you become eligible and enroll in family coverage under a DXC high deductible health plan on December 1, 2024, and are otherwise eligible to contribute to an HSA, you may make the maximum contribution for 2024 ($8,300) as if you had been eligible for the entire year, as long as you remain eligible to contribute to an HSA through December 31, 2025.

Under this same example, if you were to lose eligibility to contribute to an HSA before the end of the following year (2025 in the example), the amounts you contributed for months in which you were not actually eligible for an HSA will be included in taxable income and may be subject to a penalty tax. In this case, if you had contributed the full $8,300 in 2024, 11/12 of that amount ($7,608) would be taxable to you, because you were only eligible for the month of December.

Catch-Up Contributions to Your HSA

If you are age 55 or older, you may contribute an additional "catch-up" amount of up to $1,000 to your HSA each year. Catch-up contributions to HSAs are permitted for the entire year in which you turn 55 and are not prorated based on your birthday. For example, if you will turn 55 on December 12, 2024, you can begin making catch-up contributions as of January 1, 2024, because you will reach age 55 during that year.

Company Contributions to Your HSA

Any company contributions to your HSA account — whether earned through the DXC Healthy Behaviors Wellness Program or otherwise — will count towards your annual contribution limit. This is an IRS rule.

Important: If you enroll in the DXC Healthy Behaviors Wellness Program, be sure to reduce your payroll contribution election by the amount of wellness incentive rewards you are eligible so your annual contributions do not exceed the IRS limit and/or miss out on receiving your incentive rewards.

Carryover of HSA Account Balance

If you do not use all of the money in your HSA during any year, you may carry over your account balance and use it for future healthcare expenses.

Portability

HSAs are portable. This means that if you leave DXC or are no longer enrolled in a DXC high deductible health plan, your HSA will remain with the applicable financial institution and convert to an individual retail account; and you can continue to access the funds. Note, however, that you may be subject to a recurring administrative fee. You may continue making contributions directly to your HSA (outside of the plan) as long as you are enrolled in an eligible high deductible health plan and otherwise meet the eligibility requirements described above. If you lose HSA eligibility, you may use the funds remaining in your HSA for eligible expenses, but you may not make additional contributions.

Eligible and Incurred HSA Expenses

Important: This subsection is intended to provide a general discussion to facilitate your understanding of the limits and restrictions associated with using money from your HSA. It is not intended to provide you with personal tax or financial planning advice. Neither DXC, the plan administrator, nor the claims administrator will be held responsible for any use/misuse of the information provided in this section when making personal tax or financial planning decisions in connection with the preparation of your personal income tax return.

An HSA helps you save for healthcare expenses over your lifetime. You may use your HSA to pay eligible healthcare expenses for yourself, your spouse, or your eligible dependents that are incurred on or after the date you set up your HSA. If you use amounts in your HSA to pay for eligible healthcare expenses, you will not have to pay federal income taxes on your balance earnings and withdrawals. HSA funds that are withdrawn for non-medical reasons will be included in taxable income and generally will be subject to an additional 20% excise tax. The 20% excise tax will not apply to certain distributions made after you die or become disabled or once you reach age 65.

You can use your HSA to pay for eligible expenses not covered by any other healthcare plan. Eligible expenses include those expenses for medical care, within the meaning of Section 213(d) of the Internal Revenue Code, incurred by you and/or any Eligible Dependents (see **Special Definitions Regarding Dependents**, above), and which have not already been reimbursed.

To use HSA funds to pay for a medical expense, the expense must be incurred during the participant's period of coverage under the HSA (i.e., after the HSA account has been established). Expenses are treated as having been incurred when the participant is provided with the medical care that gives rise to the medical expense, and not when the participant is formally billed or charged for, or pays for, the medical care. Also, expenses are not treated as incurred during a period of coverage if those expenses are incurred before the date the participant first becomes enrolled under the HSA. The plan also cannot make advance reimbursement of future or expected expenses.

Some of the eligible medical expenses include, but are not limited to (as set forth in Internal Revenue Code Section 213):

- Healthcare plan deductibles and copayments including excess of reasonable and customary or recognized limits and plan annual or lifetime limits
- Alcoholism treatment program
- Chiropractors
- Communication equipment for the deaf
- Coverage continuation (COBRA) premiums
- Dentures
- Feminine care products
- Healthcare insurance premiums while receiving unemployment compensation
- Hearing aids and exams

- In vitro fertilization
- Long-term care insurance premiums (within IRS limits)
- Medical equipment rental
- Medicare and other healthcare coverage (except Medigap) if you're 65 or older and retired
- Orthodonture (braces)
- Orthopedic shoes
- Prescription drugs
- Prescription eyeglasses/contact lenses
- Psychiatrist/psychologist fees
- Routine physicals including immunizations and well-baby care
- Seeing-eye dog
- Speech therapy and learning disability counseling
- Transportation to receive healthcare
- Wheelchairs
- Weight loss programs and/or weight loss drugs, if prescribed by a physician to control a disease
- Eligible over-the-counter medical supplies, such as bandages and contact lens solution
- Eligible over-the-counter drugs, such as pain relievers, heartburn medications, allergy relief

You can also use your HSA funds to pay for certain transportation. Amounts paid for transportation primarily for, and essential to, medical care are qualified medical expenses. You must submit documentation of the corresponding medical service. Eligible expenses include but are not limited to:

- Ambulance services
- Bus*
- Car rental*
- Parking fee
- Plane fare*
- Taxi
- Toll
- Mileage reimbursement

*Long-distance travel cannot be undertaken for purely personal reasons (such as when equivalent treatment is available locally.)

Some expenses are specifically excluded, including:

- Expenses for general well-being, e.g., health club membership dues
- Cosmetic surgery (unless necessary due to disease, congenital abnormality, or accident or unless for reconstructive surgery following mastectomy)
- Electrolysis
- Hair transplants
- Healthcare insurance premiums
- Over-the-counter drugs without a written prescription

A more complete list of eligible expenses is included in IRS Publication 502, *Medical and Dental Expenses,* which is available on the Internal Revenue Service website (www.irs.gov/pub502) or by calling 1.800.829.1040. IRS Publication 502 lists expenses that qualify for federal income tax deduction and, therefore, generally also qualify for reimbursement from an HSA.

It's important to obtain and retain your receipts for tax purposes. All receipts must clearly state the services provided or that the expense was for a copayment/coinsurance amount as determined by the plan of benefits.

HSA Claims Administrator

Claims under the HSA component of the Cafeteria Program are processed by MetLife. Contact information is available in the back of this Guidebook.

Managing Your HSA Account

To manage your HSA account, initiate payments or reimbursements, make funds transfers, or download forms, access your MetLife account by logging into the DXC Benefits Center portal (myDXCbenefitscenter.com).

HSA Payments and Disbursements

Available Funds

Your HSA is like a checking account, so you will only be able to access the amount of funds that are available in your account. You should always keep your receipts for purchases or withdrawals made from your HSA, as you will need to have these receipts if you are audited by the IRS.

HSA Debit Card

After you have established your HSA with the financial institution administering DXC's HSA program, you will receive a debit card that you can use to pay for many eligible healthcare expenses, as well as other information on the HSA claims process. Use the debit card to pay for expenses directly at a pharmacy or provider's office.

If you need to pay for medical expenses up front and your pharmacy or provider does not accept your HSA debit card, you can later transfer money from your HSA account to your own linked bank account. In this way, you can pay up front using another form of payment, and then reimburse yourself from your HSA.

HSA Fees

Depending on the payment, reimbursement, and/or statement delivery method you elect, fees may apply. Be sure to check the MetLife portal for any fees that may apply to a transaction.

HSA Tax-Reporting Issues

Important: IRS regulations place the responsibility on you, as owner of the HSA, to make sure that a distribution is for a qualified medical expense. You are responsible for reporting contributions made to your HSA and for reporting distributions from it. You must determine whether the HSA distributions are taxable or whether they are used for qualified medical expenses (and, therefore, are tax-free). You should maintain sufficient records to show that any distributions you do not report as taxable were made exclusively for medical expenses, so make sure you retain your healthcare receipts for tax purposes.

When you file your income taxes, you will need to submit an IRS Form 8889 ("HSAs"). Form 8889 is an attachment to Form 1040 and is used to report HSA contributions and distributions. You will receive an IRS Form 1099-SA from the HSA administrator, which will report all the distributions made from your HSA during the year. You will need to submit a copy of your 1099-SA along with your Form 8889 when you file your federal tax returns. Copies of these forms and instructions are available on the IRS website (www.irs.gov).

Disposition of HSA Upon Death

In the event of your death, if you are married and your spouse (as determined under federal law) is your designated beneficiary, your spouse will become the owner of the account and can use the account as if it were his/her own HSA. If you are not married, or you did not designate your spouse as your HSA beneficiary, the account will no longer be treated as an HSA upon your death. The account will pass to your designated beneficiary or become part of your estate and will be subject to any applicable taxes.

Designating a Beneficiary of Your HSA Account

It is important to designate an HSA beneficiary and keep your HSA beneficiary designation current. The designation of beneficiary for your HSA is maintained by MetLife. You can designate a beneficiary of your HSA account via the MetLife portal.

Health Flexible Spending Account

Introduction, Eligibility, and General Information

The Health Flexible Spending Account (Health FSA) component of the Cafeteria Program allows you to set aside pre-tax dollars that can be used to reimburse yourself for eligible expenses of you and your Eligible Dependents (see **Special Definitions Regarding Dependents**, above).

Eligible expenses for you and your tax-qualified dependents may be reimbursed under these features regardless of whether you or your family members are enrolled in other DXC plans. See **Eligible Health FSA Expenses**, below, for a description of reimbursable expenses.

Your decision to participate in the Health FSA feature of the Cafeteria Program requires careful planning. Internal Revenue Service (IRS) regulations do not permit a refund of amounts deducted from your pre-tax salary that are not used within the applicable period of coverage. Consequently, you generally will lose any remaining Health FSA contributions left in your account(s) if not reimbursable to you for eligible healthcare incurred during the applicable period of coverage.

Contributions made to the Health FSA may not be used to reimburse expenses eligible under the Dependent Care FSA or vice versa.

The key to these benefits is understanding the expenses that are eligible for reimbursement under the Health FSA (see **Eligible Health FSA Expenses**) as well as those individuals whose expenses are eligible for reimbursement. Thus, careful planning of your anticipated expenses is advised. To assist you in this process of estimating your eligible expenses, visit the MetLife portal for a list of eligible expenses.

Please also refer to IRS Publication 502, *"Medical and Dental Expenses*," which is available on the IRS website (www.irs.gov/pub502) or by calling 1.800.829.1040. IRS Publication 502 lists expenses you may deduct from your federal income taxes, so these expenses generally qualify for reimbursement from the Health FSA.

For more information on Health FSAs, see IRS Publication 969 "*Health Savings Accounts and Other Tax-Favored Health Plans,*" which is available on the IRS website (www.irs.gov/pub969) or by calling 1.800.829.1040.

Participation in the Health FSA

The following restrictions apply to participation in a Health FSA:

- You cannot be a resident of Puerto Rico;
- You cannot enroll in both a general purpose Health FSA and a Health Savings Account (HSA) in the same plan year; and

- If you enroll in a Health FSA and you are enrolled in a DXC High Deductible Health Plan, your Health FSA will be a “limited purpose” FSA.

Health FSA Contributions and Limits

In 2024, the minimum you may contribute is $10 and the maximum you may contribute is $2,850 into your DXC Health FSA. The amount you elect will be deducted from your pay in equal amounts over all the pay periods in the plan year. The plan year begins January 1 and ends December 31. If you elect to participate or increase your annual contribution (see **Contribution Increase Rules**) after January 1 of any year, you may contribute up to the established annual maximum; and your per pay period deduction will be based on the number of pay periods remaining in the plan year on the date you join the plan or increase your annual contribution. If you are a highly compensated employee, your contributions to the Health FSA may be limited due to federal tax rules. You will be notified if you are affected by these limitations after the Annual Benefits Open Enrollment period.

Health FSA Claims Administrator

Claims under the Health FSA component of the Cafeteria Program are processed by MetLife. Contact information is available in the back of this Guidebook.

Benefits

Eligible Health FSA Expenses

Important: This subsection is intended to provide a general discussion to facilitate your understanding of the limits and restrictions associated with using money from your Health FSA. It is not intended to provide you with personal tax or financial planning advice. Neither DXC, the plan administrator, nor the claims administrator will be held responsible for any use/misuse of the information provided in this section when making personal tax or financial planning decisions in connection with the preparation of your personal income tax return.

You can use your Health FSA to reimburse yourself for eligible expenses not covered by any other healthcare plan. Eligible expenses include those expenses for medical care, within the meaning of Section 213(d) of the Internal Revenue Code, incurred by you and/or any Eligible Dependents (see **Section 14**, **DXC Technology Company Cafeteria Program**, under **Special Definitions Regarding Dependents**), and which have not already been reimbursed.

To use your Health FSA money to pay for a medical expense, the expense must be incurred during the participant’s period of coverage under the Health FSA (i.e., after the Health FSA account has been established). Expenses are treated as having been incurred when the participant is provided with the medical care that gives rise to the medical expense, and not when the participant is formally billed or charged for, or pays for the medical care. Also, expenses are not treated as incurred during a period of coverage if those expenses are incurred before the date the participant first becomes enrolled under the Health FSA. The plan also cannot make advance reimbursement of future or expected expenses.

Examples of eligible medical expenses as set forth in Internal Revenue Code Section 213 currently include:

- Healthcare plan deductibles and copayments including excess of reasonable and customary or recognized limits and plan annual or lifetime limits
- Chiropractors
- Communication equipment for the deaf
- Coverage continuation (COBRA) premiums

- Dentures
- Feminine care products
- Healthcare insurance premiums while receiving unemployment compensation
- Hearing aids and exams
- In vitro fertilization
- Long-term care insurance premiums (within IRS limits)
- Medical equipment rental
- Orthodonture (braces)
- Orthopedic shoes
- Prescription drugs
- Prescription eyeglasses/contact lenses
- Psychiatrist/psychologist fees
- Routine physicals including immunizations and well-baby care
- Speech therapy and learning disability counseling
- Wheelchairs
- Weight loss programs and/or weight loss drugs, if prescribed by a physician to control a disease
- Eligible over-the-counter medical supplies such as bandages and contact lens solution
- Eligible over-the-counter drugs, such as pain relievers, heartburn medications, allergy relief

For more information on qualified medical, dental and vision expenses, see IRS Publication 502, *Medical and DentalExpenses*. Please also visit the MetLife portal, which you can access via the DXC Benefits Center portal (myDXCbenefitscenter.com).

Paying for Qualified Medical Expenses

You can use your Health FSA funds to pay for your qualified medical expenses in two ways: 1) debit card; or 2) requesting reimbursement.

Debit Card

You will receive a debit card, which you can use to pay providers directly for your qualified medical expenses. Most medical providers can accept the Health FSA debit card; and using the debit card can generally accelerate claims processing. See below under **Documentation Requirements for Claims**. You must be actively employed by DXC to use your MetLife debit card. Your card will be deactivated if you leave the company for any reason.

Requesting Reimbursement

If you do not use your debit card, you can submit your receipts and any other required documentation to MetLife and be reimbursed using funds from your account balance. You can access the MetLife portal via the DXC Benefits Center (myDXCbenefitscenter.com). The MetLife portal offers you the convenience of creating a claim form online. Follow the instructions to submit your claims and documentation for processing. You can upload your documentation for eligible expenses directly to the MetLife portal. Once your complete claim is received, it will be processed within 5 to 10 calendar days and reimbursement sent directly to you either by bank transfer (recommended) or check. You will be reimbursed from the funds currently available in your account.

Documentation Requirements for Claims

To process all claims, MetLife requires a receipt and may require additional documentation such as a prescription or statement of medical necessity. If documentation is required for your claim, you will have 30 days from the time of claims submission to send the required documentation to MetLife.

Debit Card Transactions and Documentation

Most debit card claims can be processed automatically. If you use your debit card at an IIAS-certified business, MetLife will attempt to auto-substantiate and pay your claim based on the information collected and transmitted by the merchant. However, if the transaction includes items that are not qualified medical expenses or that require a statement of medical necessity, MetLife will require that you submit additional documentation within 30 days. If the transaction is not conducted at an IIAS-certified business, you will also be required to submit a receipt in accordance with the requirements below. If you do not submit the required documentation by the deadline, the claim will be denied and your account will be placed in overpayment status (see below under **Overpayment**).

Basic Documentation Requirement: The Valid Receipt

To be reimbursed for your claims as quickly as possible, you must send itemized receipts or other documentation to prove that expenses are eligible under the plan. Generally, the receipt must contain the following information:

1. Name of service provider or retailer
2. Date of service or purchase
3. Identity of drug or product, or description of service
4. Purchase amount for each product or service
5. Total purchase amount

If you‘ve lost your itemized receipt, contact your service provider or pharmacy to request a copy, or call your health plan for an explanation of benefits (EOB). With all claims, you also need to send a completed and signed MetLife claim form, which you can create on MetLife portal.

There may be different or additional documentation requirements depending on the nature of the service for which you are seeking reimbursement:

Medical Services Documentation Requirements

Receipts: You must provide itemized receipts that contain all of the information (per “Valid Receipt” above) and also the patient‘s name. The patient‘s name, however, isn‘t required for over-the-counter items. If the medical receipt is handwritten, it must include the service provider‘s signature. For prescription drugs, provide the receipt that the pharmacist attached to the prescription rather than the cash register receipt.

Explanation of Benefits (EOB): If you have medical insurance, proof of any amount paid by other coverage, such as an EOB, is necessary. However, an EOB isn‘t required for:

- Prescriptions
- Vision or hearing expenses
- Receipts that state the amount is for a copayment

Healthcare Supplies: Healthcare supplies are considered eligible expenses and do not require a prescription unless they are considered “dual purpose.” (See below, under Dual Purpose Items & Statement of Medical Necessity.)

Medical Necessity: Some expenses, such as vitamins, are eligible only if medically necessary. In such cases, a statement of medical necessity is required. The expense must be an eligible expense in the plan, or it won‘t be approved even if a doctor provides a statement of medical necessity. A statement of medical necessity is any document that indicates the doctor‘s name and signature, such as a prescription pad, letter, or preprinted form, and the medical reason or condition for the expense.

Dual Purpose Items & Statement of Medical Necessity: When a healthcare service or product can be used for both medical and general health reasons, it is referred to as “dual purpose.” For these items, you must provide additional information to confirm the expense is medically necessary. Some examples of items considered dual purpose are:

- Automobile modifications
- Braille books and magazines
- Cosmetic surgery
- Dental implants
- Exercise equipment
- Humidifiers
- Lodging
- Massage therapy
- Mattresses
- Prescribed food
- Sunglasses
- Support hose
- Tutoring
- Umbilical cord storage
- Vacuums
- Weight loss programs
- Wigs

The ***Statement of Medical Necessity Form*** has been created to capture all required information needed to prove a product or service is medically necessary. The form is available on the MetLife portal. The following information is required:

1. Patient name
2. Specific diagnosis, diagnosis code (ICD-9), or medical condition
3. Specific length of treatment (including a begin and end date)
4. Name of particular product or service being prescribed
5. Medical provider’s signature
6. Date (must be in the current calendar year)
7. Statement that the product or service is medically necessary and not for general health or cosmetic purposes

If you choose to have your provider write a letter, it must be on the provider’s letterhead and include the information provided above.

Dental Services Documentation Requirements

You must provide itemized receipts that contain all of the information (per “Valid Receipt” above) and also the patient‘s name. If you have dental insurance, submit your claims to that plan before submitting them to MetLife. If your receipt indicates you have dental insurance, proof of any amount paid by other coverage, such as an EOB, is necessary.

Orthodontia Services Documentation Requirements

You need to provide the following on an itemized bill that includes:

- Name of service provider
- Name of patient
- Date of service provided
- Amount being claimed
- Proof of any amount paid by other dental coverage, such as an EOB, if you have dental insurance

When Paying in Installments: If you're paying in installments, you must submit a claim and your receipt or payment coupon for each installment. You may be reimbursed:

- Monthly;
- After each installment; or
- In a one-time payment.

Travel Expenses Documentation Requirements

You're required to provide the following:

- MetLife claim form, on which you identify yourself as the provider
- A receipt with the following information:
  - Travel provider (e.g., taxi service, airline)
  - Date of travel
  - Type of expense (e.g., tolls, parking, lodging)
- Amount
- Mileage documentation, including one of the following:
  - Printout from a map or website indicating the travel distance
  - Mileage log in which you document your travel date, distance, and destination
  - For expenses of $100 or more, a statement of medical necessity is required from a doctor documenting the medical condition for which you're receiving care

Documentation Requirements for Expenses Incurred Outside the United States

To submit a claim for services received or products purchased outside of the United States, provide:

- Receipts and other documentation in English
- Expenses in U.S. dollars

If receipts and documentation are in another language besides English, they must be translated. You, the provider, or a third party can do the translation. The translation can appear on the receipts and documentation, or in a separate document. If you're unable to convert the expenses to U.S. dollars from another currency, submit them to MetLife, which will convert the amounts to dollars.

Deadline for Submitting Health FSA Claims

The deadline for submitting claims for qualified expenses incurred during the plan year is the March 31 of the following plan year. For example, the deadline for submitting claims for expenses incurred during the 2024 plan year is March 31, 2025. Claims submitted after that date will not be processed.

Denial of Claim

If a claim for benefits is wholly or partly denied, you will be furnished with written notification of the decision. This written notification will:

1. State the specific reason(s) for the denial;
2. Make specific reference to the provisions upon which the denial is based;
3. Provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4. Provide an explanation of the review procedure.

Appeal of Claim

On any claim you may appeal to DXC for a full and fair review. To do so, you:

1. Must request a review upon written application within 180 days of the date you were notified of the denial of your claim; and
2. May request copies of all documents, records, and other information relevant to the claim; and
3. May submit written comments, documents, records and other information relating to the claim.

DXC will respond in writing with its final decision on the claim within 60 days of receiving your claim.

To file an appeal, please contact the DXC Benefits Center at 1.888.305.5499.

Overpayment

Overpayment can occur when information that‘s necessary to prove that an expense was eligible, such as a receipt, isn‘t provided or adequate. Overpayments can also result from an expense that shouldn‘t have been paid by MetLife. The most common reasons for an overpayment are:

- A claim that was paid initially but later determined to be ineligible (e.g., using your debit card at a non-IIAS merchant and not submitting receipts; or using your debit card to purchase an ineligible item, or to purchase a dual-purpose item for which you did not submit supporting documentation)
- Changes made to your goal amount due to a qualified change in status, most commonly when you leave the company

Impact of an Overpayment

If your account has an overpayment amount over $100, your MetLife debit card will be suspended until the overpayment is repaid. While you‘re unable to use your card, you may submit claims on the MetLife portal, via fax, through the U.S. Postal Service, or using the mobile app. IRS rules state that failure to resolve your overpayment before the end of the plan year can result in tax implications.

Here are some suggestions to keep in mind when using your MetLife debit card:

- Always save your itemized receipts! You may need them if MetLife notifies you to provide documentation for your transaction
- Send receipts or other documentation for your transaction by the due date
- Review eligible healthcare expenses on the MetLife portal (myDXCbenefitscenter.com) to become familiar with items and services for which you can use your card
- Do not use your MetLife card to pay for ineligible healthcare items
- Consider shopping at IIAS-certified merchants, where items are automatically identified as eligible or ineligible at checkout

Errors

Every attempt is made to ensure the accuracy of your claim. If you notice an error, however, you have rights under regulations that govern debit cards. Contact MetLife as soon as possible. You must notify MetLife within 60 days of the process date on your claim. Be prepared to provide the following information:

- Your name and Social Security number
- A description of the error, along with an explanation of why you believe there is an error, or why you need more information
- The dollar amount of the suspected error

Heroes Earnings Assistance and Relief Tax Act (HEART) of 2008, H.R. 6081

A provision of this act allows a “qualified reservist distribution” (QRD) from the Health FSA if an employee is called to active duty for at least 180 days.

A qualified reservist can take a full or partial taxable withdrawal of unused Health FSA deposits. The withdrawal can be made between the date the reservist is called to active duty and the last date of the coverage period. Only one withdrawal is permitted. Amounts withdrawn as QRDs will avoid forfeiture rules under the Health FSA.

Qualified reservists may choose to continue participation in the Health FSA and continue to make contributions from any differential pay received. Since going on a military leave is a “qualified change of status,” they may also choose to terminate participation in the plan.

Online Information and Health FSA Account Management

You can manage your MetLife Health FSA account online through the DXC Benefits Center (myDXCbenefitscenter.com) or by calling 1.888.305.5499.

Explanation of Benefits/Statement of Accounts for Health FSAs

Each Health FSA reimbursement will include an Explanation of Benefits (EOB) which provides information on the claims paid in that reimbursement and provide you the current status of your Health FSA. It is your responsibility to keep a copy of all claims/receipts/EOBs submitted for reimbursement and all EOBs received from the Health FSA component of the Cafeteria Program. You will need this documentation should you be audited by the Internal Revenue Service.

Unused Health FSA Account Balances

At the end of each year, a portion of any remaining balance in your Health FSA account will carry over to the following year; provide that, such carryover amount will only be up to the annual IRS limit. Notwithstanding the carryover amount, any deposits in your Health FSA not used by the date your period of coverage ends (see **Period of Coverage**, below) or any funds not claimed by March 31 (for expenses incurred prior to the date your period of coverage ends) of the following year **will be forfeited**. IRS regulations do not permit a refund of pre-tax deductions.

Dependent Care Flexible Spending Account

Introduction, Eligibility, and General Information

The Dependent Care Flexible Spending Account (Dependent Care FSA) component of the Cafeteria Program allows you to set aside pre-tax dollars that can be used to reimburse yourself for eligible dependent care expenses (e.g., day care for dependents to allow you and your spouse, if applicable, to work).

The Dependent Care FSA is not available if you are a resident of Puerto Rico.

Eligible expenses for you and your family may be reimbursed under these features regardless of whether you or your family members are enrolled in other DXC plans. See **Eligible Dependent Care FSA Expenses** below for a description of reimbursable expenses.

Your decision to participate in the Dependent Care FSA feature of the Cafeteria Program requires careful planning. Internal Revenue Service (IRS) regulations do not permit a refund of amounts deducted from your pre-tax salary that are not used within the applicable period of coverage. Consequently, you generally will lose any remaining Dependent Care FSA contributions left in your account(s) if not reimbursable to you for eligible dependent care expenses incurred during your period of coverage. Contributions made to the Dependent Care FSA may not be used to reimburse expenses eligible under the Health FSA or vice versa.

The key to these benefits is understanding the expenses that are eligible for reimbursement under the Dependent Care FSA (see **Eligible Dependent Care FSA Expenses**) as well as those individuals whose expenses are eligible for reimbursement. Thus, careful planning of your anticipated expenses is advised. To assist you in this process of estimating your expenses, visit the MetLife portal at myDXCbenefits.com for a list of eligible expenses.

Eligible Dependents

For expenses to be reimbursable under the Dependent Care FSA, the person for whom you are providing care must meet the definition of **Eligible Dependent** (see **Special Definitions Regarding Dependents**, above), **and** one of the following requirements:

- Be under age 13 if she/he is your “qualifying child” under the IRS rules; have the same principal abode as you for more than half the year; and provides less than one-half of his or her own support for the year; or
- Be your spouse or another “tax dependent” under the IRS rules who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the year.

Dependent Care FSA Contributions and Limits

If you are a dual-income or single parent (head of household) family, up to $5,000 may be contributed into your Dependent Care FSA each year. If you are married and filing separate tax returns, the annual maximum is $2,500 per parent. The amount you select will be deducted from your pay in equal amounts over all pay periods in the plan year. The minimum annual contribution to establish your DXC Dependent Care FSA is $10.

If you enroll in the plan or increase/decrease your annual contribution after January 1 of any year, you may contribute up to the established annual maximum and your per pay period deduction will be based on the number of pay periods remaining in the plan year on the date you enroll in the plan or increase your annual contribution.

Federal tax rules impose limits on contributions to the Dependent Care FSA in certain situations that help ensure that the plan does not unfairly favor highly compensated employees. As a result, it may be necessary to reduce contributions for some participants under these rules. You will be notified if you are affected by these limitations after the Annual Benefits Open Enrollment period.

The annual maximum contribution amounts shown above are the maximums allowed in any one year under the Internal Revenue Code. If you participate in more than one Dependent Care plan in the same year (e.g., through a prior employer or your spouse's employer), it is your responsibility to ensure that total contributions to all Dependent Care plans in the same year do not exceed the maximum allowed. Any excess is subject to taxation when you file your federal and state (if applicable) income tax return(s).

Because Dependent Care expenses qualify for a federal tax credit, you should compare the potential savings from the tax credit with those from the Dependent Care FSA and choose the approach that best meets your needs.

Expenses eligible for the tax credit will be reduced dollar for dollar by any expenses reimbursed through the Dependent Care FSA. In addition, state dependent care tax credits (if available in your state of residence) may also be affected by your participation in the plan. If you are unsure as to which method would be better for you, speak with your tax advisor.

Eligible Dependent Care Expenses

Eligible Dependent Care expenses are reimbursable when your dependents require day care to allow you (and your spouse, if applicable) to work full-time or part-time. If you are married, your spouse must also receive income from employment, attend school full time for at least five months during the year, or be disabled.

Eligible Dependent Care expenses include employment-related expenses, within the meaning of Section 21(b) of the Internal Revenue Code, with respect to your Eligible Dependents. For a list of eligible and ineligible Dependent Care FSA expenses, see IRS Publication 503, "*Child and Dependent Care Expenses*," which is available on the IRS website (www.irs.gov) or by calling 1.800.829.1040. IRS Publication 503 lists expenses that qualify for the federal dependent care tax credit and, therefore, generally also qualify for reimbursement from the Dependent Care FSA.

Eligible employment-related expenses (as set forth in Internal Revenue Code Section 21) currently include:

- Child day care or babysitting services inside your home or someone else's home
- Adult day care inside your home or someone else's home
- Certain expenses of a full-time live-in caretaker (to take care of your dependent)
- Charges by a licensed day care facility
- Expenses for summer day camp (provided no significant educational services are provided at the camp)
- Before and after school day care

Eligible employment-related expenses also include the cost of nursery school, preschool, and similar programs below the level of kindergarten, night-time care expenses (if certain conditions are met), and indirect expenses, such as application fees, agency fees, and non-forfeited deposits if the expense is required to obtain employment-related care and the qualifying individual must actually receive the care.

If services are provided in a childcare center, the center must provide care for more than 6 children, be paid for the care of the children, and comply with all applicable federal, state, and local requirements.

Your reimbursed expenses cannot exceed your compensation or your spouse's compensation, whichever is less. (For each month your spouse is disabled or a full-time student, your spouse's income is deemed to be $250 a month if you have one dependent or $500 a month if you have more than one dependent.)

Generally, amounts paid to a relative for the care of a qualifying individual are reimbursable, except for payments to the following relatives:

- Any relative claimed as your dependent or your spouse's dependent
- Your child, stepchild, or eligible foster child who is under the age of 19
- Your spouse
- A parent of the qualifying child

Expenses that are specifically excluded include:

- Expenses incurred while both parents are not working (or disabled or full-time students) are specifically excluded, with the possible exception of a "temporary leave of absence" as defined by the IRS.
- Child day care by your spouse or someone you could claim as your dependent on your income tax return
- Dependent Care expenses you claim to obtain a tax credit on your income tax return
- Educational expenses
- Food and clothing expenses for your dependent
- Housekeeping expenses not related to Dependent Care
- Transportation expenses (unless provided by the day care provider)
- Any portion of overnight camp

The Cafeteria Program Cannot Pay Future or Expected Expenses

In addition, expenses are not reimbursable once an individual no longer qualifies as your dependent for purposes of Section 21(b) of the Internal Revenue Code (e.g., the date your dependent child reaches 13 years of age for Dependent Care expenses or if the child is no longer your dependent due to separation or divorce). It is your responsibility to notify the DXC Benefits Center (http://yourbenefitsresources.com/dxc) within 30 days of a qualified change of status (see **Annual Benefits Open Enrollment Period** and **Changing Your Elections**) that you wish to change your election. Eligible expenses are subject to change based on IRS regulations.

Dependent Care FSA Claims Administrator

Claims under the Dependent Care FSA component of the Cafeteria Program are processed by MetLife, which is the FSA claims administrator. Contact information is available in the back of this Guidebook.

Note: MetLife became the FSA claims administrator beginning in the 2024 plan year. FSA claims related to the 2023 plan year should still be submitted via Smart-Choice.

Dependent Care FSA Claims Submission and Processing

FSA Claims Documentation

IRS rules provide that reimbursement may be made for eligible expenses only if the participant provides a written statement from an independent third party stating that the expense has been incurred and listing the amount of such expense. Generally, the following constitute sufficient documentation.

Dependent Care Expense Documentation: You must furnish the

1. Name, full mailing address, and the Social Security or other tax identification number of the Dependent Care provider (or business)
2. Name of the dependent for whom services were received
3. Itemized receipt showing the dates Dependent Care services were provided, and
4. A Dependent Care FSA Reimbursement claim form

Please Note: Canceled checks are not acceptable as receipts for dependent care expenses.

Dependent Care FSA Claims Submission

Submit claims via the MetLife portal at myDXCbenefitscenter.com (preferred), or on a paper FSA reimbursement claim form, which can be downloaded from MetLife. For assistance on claims submission, call the DXC Benefits Center (1.888.305.5499).

Reimbursement can only be made for expenses incurred during your or your family member's period of coverage (see **Period of Coverage** and **Contribution Increase Rules**) during any Dependent Care FSA plan year. For example, claims submitted against contributions made during plan year 2024 must be incurred during your period of coverage in 2024. The plan cannot pay expenses incurred prior to the individual's enrollment or for future or expected expenses.

You must submit a valid claim for Dependent Care FSA Reimbursement, as described above under **FSA Claims Documentation, Dependent Care Expense Documentation**. It is your responsibility to keep a copy of all receipts submitted for reimbursement and all EOBs received from the Dependent Care FSA. You will need this documentation **in the event you are audited by the Internal Revenue Service**.

Dependent Care FSA Reimbursement Processing

Dependent Care reimbursements will be processed up to the amount available in your Dependent Care FSA. If the amount of eligible Dependent Care expenses submitted is more than you have in your current account, the unpaid balance will be carried forward until sufficient funds are available in your Dependent Care FSA.

You have until March 31 of each year to submit claims for expenses incurred during the previous year's period of coverage.

Appeal of Claim

On any claim you may appeal to DXC for a full and fair review. To do so, you:

1. Must request a review upon written application within 180 days of the date you were notified of the denial of your claim; and
2. May request copies of all documents, records, and other information relevant to the claim; and
3. May submit written comments, documents, records and other information relating to the claim. DXC will respond in writing with its final decision on the claim within 60 days of receiving your claim. To file an appeal, please contact the DXC Benefits Center at 1.888.305.5499.

Online Information and Dependent Care FSA Account Management

Manage your MetLife Dependent Care FSA account online (myDXCbenefitscenter.com) or by calling 1.888.305.5499.

Explanation of Benefits/Statement of Accounts for Dependent Care FSAs

Each Dependent Care FSA reimbursement will include an Explanation of Benefits (EOB) which will provide information on the claims paid in that reimbursement and provide you the current status of your FSA(s). It is your responsibility to keep a copy of all claims/receipts/EOBs submitted for reimbursement and all EOBs received from the Dependent Care FSA component of the Cafeteria Program. You will need this documentation in the event you are audited by the IRS.

Unused Dependent Care FSA Account Balances

Any deposits in your Dependent Care FSA not used by the date your period of coverage ends (see **Period of Coverage**, below) or any funds not claimed by March 31 (for expenses incurred prior to the date your period of coverage ends) of the following year **will be forfeited**. IRS regulations do not permit a refund of pre-tax deductions.

Enrollment And Participation in the Cafeteria Program

This section contains general information on enrolling and participating in DXC's Cafeteria Program.

Participating in the Cafeteria Program

If you are eligible to participate in the Cafeteria Program and wish to enroll in one or more components of the program, complete your enrollment online by accessing the DXC Benefits Center (myDXCbenefits.com). By submitting your enrollment elections, you will be authorizing pre-tax contributions through payroll deductions to the DXC Technology Company Cafeteria Program. To enroll your Eligible Dependents, you must also provide their information (e.g., names, dates of birth, Social Security numbers).

Initial Eligibility & Enrollment

If your enrollment election is received and processed prior to your date of hire, your participation in the Pre-Tax Contribution component of the program will be effective on your hire date. If you enroll within 30 days of the date you first become eligible to participate, as outlined above, your elections and contributions will generally be effective retroactive to your hire date. (Note that some benefits, such as certain levels of Supplemental Life insurance, may have different effective date rules, such as evidence of insurability requirements and/or deferred effective date rules.) Refunds of contributions are not allowed. It is your responsibility to review your remuneration statement (paystub) in a timely manner to confirm deductions accurately reflect your elections.

Annual Benefits Open Enrollment

The plan year runs from January 1 to December 31. Each year you will be given an opportunity to enroll, waive, or continue participation in the components/features of the Cafeteria Program. The Annual Benefits Open Enrollment (Annual Enrollment) period is normally held each October/November, and elections made during Benefits Annual Enrollment have an effective date of January 1. It is your responsibility to read and understand the material provided to you for each Annual Enrollment.

Unless the company communicates otherwise prior to Annual Enrollment, your enrollment elections relating to the Pre-Tax Contribution component will continue each year as previously elected, but at new plan year prices, unless you make a change during the Annual Enrollment period. This must not be interpreted as a promise or guarantee that the same benefit plans will be available to you from one year to the next.

Enrollment in the Flexible Spending Account (FSA) components or the Health Savings Account (HSA) component is **not** automatic. You must enroll in these components during Annual Enrollment for each plan year in which you want to participate.

Changing Your Cafeteria Plan Elections

Any benefit elections you make under the Cafeteria Program (other than HSA elections) during your initial eligibility period or during a Benefits Annual Enrollment period, including default elections, generally cannot be changed until the next Annual Enrollment period. Your elections under the Pre-Tax Contribution and Flexible Spending Account components of the Cafeteria Program are irrevocable and binding until the next Annual Enrollment period, 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 component of the Cafeteria Program throughout the year on a prospective basis, as described below.

> **NOTE:** The Pre-Tax Contribution program is the Cafeteria Program component through which employee contributions for the medical, dental, vision, Supplemental Life and Supplemental AD&D coverages are made on a pre-tax basis.

Changing Elections for Dependents Who are Not Cafeteria Program Eligible

As described above under **Pre-Tax Contributions**, existing federal tax laws mandate that coverage for eligible family members who are **NOT** Eligible Dependents must be provided on a post-tax basis outside of the Cafeteria Program. Rules similar to those outlined below, which describe permitted mid-year election changes under the Cafeteria Program, apply when making mid-year election changes for benefits provided on a post-tax basis outside the Cafeteria Program. For example, if your adult child under the age of 26, who is not your tax dependent, loses coverage from their employer, and you wish to elect medical coverage for that child outside of an Annual Enrollment period, you must file an election within 30 days of the child's loss of other coverage. Contact the DXC Benefits Center (myDXCbenefitscenter.com) or call 1.888.305.5499) if you have questions about your ability to make mid-year election changes relating to eligible family members who are not Eligible Dependents.

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 will 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 will 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 the following conditions:

- The affected person is otherwise eligible under the Plan;
- 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
  - 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 of employer contributions

Qualified Change of Status

All requests for a change in coverage as a result of a qualified change of status must be registered with the DXC Benefits Center (myDXCbenefitscenter.com) 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 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.,Spouse/Child Supplemental Life, Short-Term Disability, and Long-Term Disability coverage.

Pre-Tax Benefit Contributions and Health FSA Election Changes

If you or one or more of your Eligible Dependents becomes eligible for benefit coverage(s) due to a qualified change of status, you may enroll yourself as well as any Cafeteria Program Eligible Dependent in the Pre-Tax Contribution component of the Cafeteria Program. The Pre-Tax Contribution program is the Cafeteria Program component through which employee contributions for the medical, dental, vision, Supplemental Life and Supplemental AD&D coverages are made on a pre-tax basis. Similarly, you may discontinue participation in the above-mentioned coverage(s) due to a qualified change of status. You may also enroll in or increase (but not disenroll from or decrease) your contributions to a Health FSA.

The following events constitute a qualified change of status for the Pre-Tax Contribution and the Health FSA components of the Cafeteria Program:

#	Qualified Change of Status for Pre-Tax Contributions and Health FSA Participation
1.	Marriage, divorce, legal separation, annulment Note: A “legal separation” is a separation pursuant to a court order that defines legally enforceable rights and obligations of the parties. Merely living apart is not a legal separation.
2.	Childbirth, adoption or placement for adoption of a child
3.	Death of your DXC Technology Company Cafeteria Program Eligible Dependent (“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 or your Eligible Dependent becomes eligible for coverage
9.	Compliance with a judgment, decree, or order relating to specified coverage for a child resulting from a divorce, annulment, or legal separation, including a 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

Dependent Care FSA Election Changes

In the case of a Dependent Care FSA, if you have a qualified change of status, you are permitted to initiate or terminate enrollment or to increase or decrease contributions. The following events are considered qualified changes of status under the Dependent Care FSA component of the Cafeteria Program:

	Qualified Change of Status: Dependent Care FSA (Initiate or terminate participation, increase or decrease contributions)
1.	Marriage, divorce, legal separation, or annulment
2.	Childbirth, adoption, or placement of a child for adoption
3.	Death of your Eligible Dependent
4.	Spouse 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 Eligible Dependent's plan from his/her 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 Eligible Dependents if any of these individuals loses coverage under any group health plan sponsored by a governmental or educational institution.
- **Medicare:** You may prospectively elect to cancel coverage for you or your Eligible Dependents when the affected person becomes entitled to coverage (i.e., becomes enrolled) under Medicare or Medicaid. You may also prospectively elect to initiate coverage for you or your 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 and required documentation must be received within 30 calendar days of the date the change was requested.

Changing Elections/Effective Date of Enrollment Changes

If you are entitled to change your enrollment, you must register the life event and make changes at the DXC Benefit Center enrollment portal (myDXCbenefits.com). You must register the event within 30 calendar days of the date the change of status occurs. Documentation supporting the change of status must be provided within 30 calendar days of the date you register the event in the DXC Benefits Center site.

Unlike during Annual Enrollment, once you enter your new benefit elections and submit them, they are irrevocable. There is no "enrollment period" or window during which you can make changes.

Elections and contributions will be effective the date of the qualified life event. Retroactive refunds are not allowed. It is your responsibility to review your remuneration statement (paystub) to confirm deductions accurately reflect your elections.

If the request for change in coverage is received within 30 calendar days of the event, coverage becomes effective as follows:

- Coverage of a child due to that child's birth, adoption, or legal guardianship is effective the date of the event
- Coverage changes for all other qualified changes of status are effective the date of the life event

Note that any changes requiring evidence of insurability may have different effective date rules. Also, certain benefit options may contain deferred enrollment provisions. Any request for change in coverage that is received more than 30 calendar days after the change of status will not be processed. Your next opportunity to change your enrollment will be during the next Annual Enrollment period.

HSA Contribution Election Changes

You may change or revoke your HSA contribution election at any time during the year on a prospective basis. That is, you can start, increase, decrease, or stop the contributions you make to your HSA at any time during the year, but your election change will be effective only for future payroll periods. If you enroll in an HSA mid-year (as opposed to during Annual Enrollment), your account will be open as soon as administratively possible, but no sooner than the first of the following month in which the change was made (per IRS guidelines). Note: you may not see the change to your paycheck until the second paycheck you receive in the following month.

Effective Date of FSA Election Changes

If you increase contributions to your Health FSA or Dependent Care FSA as a result of a qualified change of status event that is caused by the addition of a covered family member, claims for the newly enrolled family member must be incurred during that person's period of coverage in that plan year (see **Period of Coverage**). With the exception of the birth of a child, claims incurred by the newly enrolled family member prior to their effective date of coverage are not reimbursable under the Health FSA. In the case of the birth of a child, the child's expenses would be eligible for reimbursement retroactively to the date of birth.

The full annual contribution amount is available to the employee and any eligible family member after the increase is effective. Any claims incurred prior to the date contributions are increased will be limited to the contribution amount prior to the increase. Again, the exception would be for the birth of a child, whose expenses would be eligible retroactive to his or her birthdate.

For example: On January 1, you elect to contribute an annual amount of $1,500. On August 26, you have a child; therefore, on September 1, you increase your annual contribution to $2,000.

- Claims incurred by the child between August 26 and December 31 may be submitted for reimbursement up to the new annual election of $2,000; claims incurred by the child prior to August 26 are not eligible for reimbursement
- Claims incurred for any eligible family member may be submitted up to the new annual election of $2,000; however, claims incurred for eligible family members prior to September 1 are limited to the contribution amount prior to the increase (i.e., $1,500)

Period Of Coverage

Your period of coverage under the Cafeteria Program begins on the first day for which pre-tax deductions are taken for contributions to the applicable program component. However, if you elect to open an HSA mid-year (as opposed to during Annual Enrollment), your account will be opened as soon as administratively possible, but no sooner than the first of the following month (per IRS guidelines).

If your participation and contributions under any component/feature of the DXC Technology Company Cafeteria Program end in the middle of the plan year, because of termination of employment, you may re-enroll upon re-employment. However, in the case of re-employment within 30 days of termination, your prior benefit elections shall be reinstated automatically (i.e., you are not permitted to make changes to elections that were in effect on the day you terminated).

Your period of coverage for each program component/feature of the Cafeteria Program will end as described below.

Pre-Tax Contribution Plan

Your period of coverage ends on the earlier of the date you:

- Elect to waive participation in all plans for which pre-tax contributions are allowed (medical, dental, vision, Supplemental Life, and Supplemental AD&D)
- No longer meet the definition of an eligible employee
- Fail to make premium payments while on an approved leave of absence (see the **DXC U.S. Leaves of Absence Without Pay** and **DXC U.S. Leaves of Absences With Pay** policies regarding premium payment requirements to continue benefits coverage while on a leave of absence. Policies are available in Employee Connect)

Health FSA

Your period of coverage ends on the earlier of:

- December 31 of the plan year (and you do not re-enroll in the Health FSA for the subsequent year)
- The date you no longer meet the definition of an eligible employee
- The date you fail to make required COBRA premium payments
- The date you fail to make premium payments while on an approved leave of absence (see **the DXC U.S. Leaves of Absence with Pay** and **DXC U.S. Leaves of Absence without Pay** policies regarding premium payment requirements to continue benefits coverage while on a leave of absence. Policies are available in Employee Connect)

Dependent Care FSA

Your period of coverage ends on the earlier of:

- December 31 of the plan year (and you do not re-enroll in the Dependent Care FSA for the subsequent year)
- The date you revoke your election due to a qualified change of status or as specifically permitted above (see **Enrollment and Participation in Cafeteria Plans** and **Changing Your Cafeteria Plan Elections**)

Health Savings Account

Your period of pre-tax contributions ends on the earlier of the date:

- December 31 of the plan year (and you do not re-enroll in the Health Savings Account for the subsequent year)
- You are no longer enrolled in a DXC high deductible health plan
- You can be claimed as another person's tax dependent (even if s/he does not actively claim you as a tax dependent)
- You are enrolled in Medicare coverage
- You are covered under a general healthcare flexible spending account (e.g., the Health FSA) or a health reimbursement account, including coverage available through a spouse's plan
- You have any health coverage other than a DXC high deductible health plan (except for certain limited types of coverage, discussed below)

The following types of healthcare coverage do not count as "health coverage other than a DXC high deductible health plan" for purposes of terminating HSA contribution eligibility:

- Insurance for a specific disease or illness (such a cancer insurance)
- Accident, disability, dental care, vision care, or long-term care insurance
- Drug discount cards
- Insurance that pays a fixed amount her day (or other period) of hospitalization (such as hospital indemnity insurance)

- Most employee assistance programs (such as the DXC LifeManagement Program), disease management programs, and wellness programs
- A Limited Purpose Health Flexible Spending Account (Limited Purpose FSA) or Limited Purpose Health Reimbursement Account (HRA) (note that DXC does not offer a Limited Purpose FSA)
- Insurance for liabilities under worker's compensation laws, tort liabilities, or liabilities relating to ownership or use of property (such as homeowner or auto insurance)

Continuation of Coverage

If you take an authorized leave of absence, you may be able to continue participation in Cafeteria Program benefits by paying for them directly on a post-tax basis. You will be billed directly by the DXC Benefits Center, the DXC COBRA administrator and direct billing administrator. **Coverage will be canceled retroactively to the last date for which payment was received if payments are not received within 30 days of the date they are due (the grace period).** If you have questions about your payment options for other cafeteria program components while on leave of absence, contact the DXC Benefits Center (1.888.305.5499).

Loss of Employment or Reduction in Hours

If you end employment or become ineligible due to a reduction in hours, you may extend your period of coverage in certain benefits, by electing to continue your contributions under the Consolidated Omnibus Budget Reconciliation Act (COBRA). (See **COBRA Rights** under **Section 6**). Note that Dependent Care FSA is not a COBRA eligible plan, however you may submit Dependent Care FSA claims incurred during the plan year, even after your employment ends, up to your remaining balance, for services provided before your termination date.

Effect On Other Benefits

Converting part of your salary to pre-tax dollars generally has no effect on your other DXC-sponsored benefit plans.

All benefits that are based on your pay will be calculated before pre-tax contributions. However, DXC is required to comply with certain nondiscrimination laws that may require an adjustment of a pre-tax contribution. In the event of this occurrence you will be notified.

Your benefits from government-sponsored plans, such as Social Security, may be affected. For example, you are paying Social Security taxes on a lower amount of income; therefore, you may receive a slightly smaller Social Security benefit at retirement. This applies if your salary is below the Social Security wage base.

Modification Or Suspension of Elections

DXC may suspend or reduce the contribution elections of some participants to satisfy nondiscrimination requirements or other state or federal laws.

No Guarantee of Tax Consequences

The tax advantages that this program is intended to provide are subject to governmental rulings, regulations and application of the tax laws by the IRS. Although DXC may anticipate certain tax consequences as being likely and intends that the operation of the plan will result in those tax results, DXC does not promise or represent to any person that any particular tax consequences will result by participating in the plan.

Section 15

ERISA Information

ERISA Information

Introduction

This Guidebook presents the major provisions of certain DXC employee benefit plans. In addition to the information already provided, there is other information you are entitled to know about your benefits, as required by the Employee Retirement Income Security Act of 1974 (ERISA). This information includes:

- How the plans are administered
- The rights you and your beneficiaries have as members in these plans.

This section of the Guidebook provides you with that information.

General Administrative Information

Plan Sponsor

DXC Technology Services LLC, a wholly owned subsidiary of DXC Technology Company (“DXC”), is the legal plan sponsor of all the employee benefit plans detailed in this Guidebook.

Plan Administrator

The DXC Employee Benefits Fiduciary Committee is the Plan Administrator and is responsible for the control and management of the benefit plans discussed in this Guidebook. You can contact the Plan Administrator at the following address and phone number:

DXC Employee Benefits Fiduciary Committee
c/o DXC Technology Corporate Employee Benefits Department
20408 Bashan Drive, Suite 231
Ashburn, VA 20147
(855)657-2394

Internal Revenue Service

Information required by the IRS with respect to the healthcare coverages (including prescription drug, vision and dental benefits), retirement income, life, accidental death and dismemberment, short-term disability, long-term disability, long-term care, employee assistance program, Flexible Spending Account, and Health Savings Account plans, is filed under DXC Technology Services LLC’s employer identification number 82-2287119.

Agent for Service of Process

DXC‘s agent for service of legal process in all jurisdictions of the United States is CT Corporation System. Service of legal process may also be made upon the plan trustee or plan administrator. Make all legal contacts through the plan administrator at the address above.

General Administrative and Funding Information About the Welfare Plans

Except where otherwise noted, the benefits described in this Guidebook are provided through a number of plans subject to ERISA.

ERISA defines these types of plans as welfare plans. A name and number under ERISA identify each plan. This information is provided in the Welfare Plan Information chart later in this section.

Some of the benefits for active employees described in this Guidebook are self-insured, including the employee Flexible Spending Account and Health Reimbursement Account benefits. These benefits are not guaranteed under a contract of insurance. Instead, they are paid through general assets of the company. By contrast, the medical, dental, and vision benefits described in this Guidebook are fully-funded and provided through group insurance policies.

DXC maintains the records for the welfare plans. Records are currently kept on a January 1 to December 31 plan year. These records and the plan documents are available for review at:

DXC Technology Company
Corporate Employee Benefits Department
20408 Bashan Drive, Suite 231
Ashburn, VA 20147

The various welfare benefits are funded by a combination of employee and employer contributions, as indicated elsewhere in this Guidebook. If premiums received by the life insurance companies exceed claims paid, in some instances, the life insurance companies pay dividends or give experience-rated refunds or credits. DXC reserves the right to a share of any dividends, refunds, or credits payable by the insurance companies, which will be determined by multiplying the refund by a fraction equal to contributions from DXC for the plan year generating the dividend, refund or credit, divided by the combined total contributions from DXC and employees for that plan year.

The DXC Technology Company Cafeteria Program (which includes the Pre-Tax Contribution and Flexible Spending Account Plan components) is intended to qualify under Section 125 of the Internal Revenue Code. This allows contributions required toward participation in plans offering medical, prescription drug, vision, dental, supplemental life insurance, or supplemental accidental death and dismemberment benefits to be made from your pre-tax salary and generally requires that employee coverage elections be binding for a period of 12 months.

All plans are established for the exclusive benefit of you, your covered family members, or your beneficiaries. DXC intends that the terms of all plans be legally enforceable.

Claims and Appeals

Please refer to the procedures for filing claims as listed in each section of this Guidebook. Generally, claims will be filed with the applicable carrier or claims administrator; appeals will be handled by the carrier or claims administrator as well. All claims and appeals will be handled in accordance with the procedures provided to you by the carrier or claims administrator, in compliance with the Department of Labor Claim Procedures, which procedures shall comply with the provisions of ERISA, including Section 715 and the regulations promulgated by the Department of Labor, specifically Labor Regulations Section 2560.503-1, as well as additional procedures required as part of PPACA pursuant to Section 2719. For assistance with appeals, please contact the DXC Benefits Center at 1.888.305.5499.

Welfare Plan Continuation

While CSC may elect to continue the welfare benefit plans indefinitely, CSC reserves the right to revise or discontinue any or all of these plans or benefits at any time with or without advance notice. All benefits are subject to the provisions of the plan documents. No one shall accrue any rights because of any statement in or omission from this document. No statement or omission shall modify or affect the plan documents.

Plan Sponsor

DXC Technology Services LLC, a wholly owned subsidiary of DXC Technology Company (“DXC”), is the legal plan sponsor for all of the plans listed on the following pages. This Guidebook pertains to benefits provided through the **DXC Self-Insured Employee Welfare Benefits Plan (Plan #501).** It also covers certain insured benefits provided through the **DXC Fully Insured Employee Welfare Benefits Plan (Plan #502)**. Certain subsidiaries and affiliates of DXC are participating employers in these plans as indicated in the chart.

Benefits provided under collective bargaining agreements (CBAs) may vary. See your CBA for details, if applicable.

Group Benefit Plan #501: The DXC Self-Insured Employee Welfare Benefits Plan

Features of Plan #501	Administrator/ Insurance Company	Plan Sponsor and Participating Employers	Exceptions to Employee Participation
The DXC Self-Insured Employee Welfare Benefits Plan See plan components and features below	See details below	• Computer Sciences Corporation • DXC Technology Company • Axon Puerto Rico, Inc • Concerto Cloud Services, LLC • CSC Consulting, Inc. • CSC Covansys Corporation • DXC US Agility Platform, Inc. • DXC Technology Services LLC • eBECS North America Inc. • Fruition Partners Inc. • Sable37, Inc. • SBB Services, Inc. • Tribridge Holdings, LLC • UXC Eclipse (USA) Inc. • UXC Eclipse (USA) LLC • UXC Eclipse (AES) LLC • Wendover Financial Services Corp. • Xchanging Solutions (USA), Inc. • Xchanging Systems and Services, Inc.	**U.S. Payroll:** Employees must be on a U.S. payroll to be eligible for these benefits. Not all benefits are available to all employees. **Geographic Residence:** Not all benefits are available to all employees on a U.S. payroll. Any restrictions based on geographic residence are noted below. **Employees on Non-U.S. Payroll:** Employees working in the U.S. while receiving all or part of their pay from a non-U.S. payroll are not eligible to participate in any features of this Plan, or to receive benefits from any features of this Plan.[1] **Collectively Bargained Employees**: If you are part of a collective bargaining group, please check your collective bargaining agreement to ascertain what benefits are available to you and the terms under which they are offered.

(1) Even if you are treated as an employee of a participating employer for tax purposes and issued a W-2, or treated as an employee of a participating employer for FMLA purposes, you will not receive U.S. benefits for periods where you are also receiving all or some base pay from a non-U.S. payroll.

Components of Group Benefit Plan #501: The DXC Self-Insured Employee Welfare Benefits Plan

Component	Administrator	Employee Group	Eligible Geography	Group Number/ Policy Number
"DXC Technology Company Cafeteria Program" including these features: • Health Savings Account (HSA) • Health Flexible Spending Account • Dependent Care Flexible Spending Account	Businessolver	ACTIVE, COBRA	• U.S. • U.S. Virgin Islands (U.S.V.I.) • Puerto Rico (pre-tax contribution feature only)	N/A
"DXC Health Reimbursement Account"	MetLife	ACTIVE	U.S.	N/A
"DXC Commuter Reimbursement Account Plan"	Metlife	ACTIVE	U.S.	N/A
"Healthy Behaviors Wellness Program" (for employees enrolled in a DXC high deductible health plan)	Virgin Pulse	ACTIVE, COBRA	U.S.	N/A

Group Benefit Plan #502: DXC Fully-Insured Employee Welfare Benefits Plan

Features of Plan #502	Administrator/ Insurance Company	Plan Sponsor and Participating Employers	Exceptions to Employee Participation
DXC Fully-Insured Employee Welfare Benefits Plan See plan components and features below	See details below	• Computer Sciences Corporation • DXC Technology Company • Axon Puerto Rico, Inc. • Concerto Cloud Services, LLC • CSC Consulting, Inc. • CSC Covansys Corporation • DXC US Agility Platform, Inc. • DXC Technology Services LLC • eBECS North America Inc. • Fruition Partners Inc. • Sable37, Inc. • SBB Services, Inc. • Tribridge Holdings, LLC • UXC Eclipse (USA) Inc. • UXC Eclipse (USA) LLC • UXC Eclipse (AES) LLC • Wendover Financial Services Corp. • Xchanging Solutions (USA), Inc. • Xchanging Systems and Services, Inc.	**U.S. Payroll:** Employees must be on a U.S. payroll to be eligible for these benefits. Not all benefits are available to all employees. **Geographic Residence:** Not all benefits are available to all employees on a U.S. payroll. Any restrictions based on geographic residence are noted below. **Employees on Non-U.S. Payroll:** Employees working in the U.S. while receiving all or part of their pay from a non-U.S. payroll are not eligible to participate in any features of this Plan, or to receive benefits from any features of this Plan.[1] **Collectively Bargained Employees:** If you are part of a collective bargaining group, please check your collective bargaining agreement to ascertain what benefits are available to you and the terms under which they are offered.

(1) Even if you are treated as an employee of a participating employer for tax purposes and issued a W-2, or treated as an employee of a participating employer for FMLA purposes, you will not receive U.S. benefits for periods where you are also receiving all or some base pay from a non-U.S. payroll.

Components of Group Benefit Plan #502: DXC Fully-Insured Employee Welfare Benefits Plan

Line of Coverage	Carrier	Employee Group	Eligible Geography	Group Number/ Policy Number
“Basic Employee Life,” “Employee Supplemental Life,” “Spouse/Child Supplemental Life”	Metropolitan Life Insurance Company	ACTIVE	U.S., Puerto Rico, U.S.V.I.	158555-2-G
“Short-Term Disability Insurance” “Long-Term Disability Insurance”	The Hartford	ACTIVE	U.S., Puerto Rico, U.S.V.I.	GRH-402775 GLT-402775
“Accidental Death and Dismemberment (AD&D) Plan”	Zurich American Life	ACTIVE	U.S., Puerto Rico, U.S.V.I.	GTU-0207328
“Business Travel Accident (BTA) Accidental Death and Dismemberment (AD&D) Plan” (including war risk)	Zurich American	ACTIVE	U.S., Puerto Rico, U.S.V.I.	GTU-0207327
“DXC LifeManagement Program”	Magellan Behavioral Health	ACTIVE, COBRA	U.S., Puerto Rico, U.S.V.I.	HR-003-89

See below for Medical Insurance, Dental Insurance, and Vision Insurance components.

Medical Insurance Components of Group Benefit Plan #502: DXC Fully-Insured Employee Welfare Benefits Plan

Carrier	Plan(s)	Coverage Tier	Employee Group	Eligible Geography	Group Number/ Policy Number
Aetna Life Insurance Co.	Bronze, Bronze Plus, Silver, Gold, Platinum	All	ACTIVE, COBRA	U.S. (except Hawaii)	868574
Anthem BlueCross BlueShield	Bronze, Bronze Plus, Silver, Gold, Platinum	All	ACTIVE, COBRA	U.S. (except Hawaii)	201087
Cigna Global Health (includes Dental and Vision)	All	All	ACTIVE, COBRA	Outside of U.S., and in U.S.V.I.	07410A

Medical Insurance Components of Group Benefit Plan #502: DXC Fully-Insured Employee Welfare Benefits Plan

Carrier	Plan(s)	Coverage Tier	Employee Group	Eligible Geography	Group Number/ Policy Number
Cigna Health & Life Insurance Co.	Bronze, Bronze Plus, Silver, Gold, Platinum	All	ACTIVE, COBRA	U.S. (except Hawaii)	3339131
Dean Health Plan	Bronze, Bronze Plus, Silver, Gold, Platinum	All	ACTIVE, COBRA	Milwaukee/Madison, WI and southern WI	14SIYAP
Dean Health Plan (Prevea360)	Bronze, Bronze Plus, Silver, Gold, Platinum	All	ACTIVE, COBRA	Green Bay, WI area and northern WI	14SIYAW
Geisinger Quality Options, Inc.	Bronze, Bronze Plus, Silver, Gold, Platinum	All	ACTIVE, COBRA	Pennsylvania & New Jersey	10117633
Hawai'i Medical Service Association (HMSA)	Gold, Platinum	All	ACTIVE, COBRA	Hawaii	97151
Health Net of California	Bronze	EE, EE+Spouse, EE+Family	ACTIVE	Northern CA	PC027A
Health Net of California	Bronze	EE+Child(ren)	ACTIVE	Northern CA	PC027B
Health Net of California	Bronze Plus	EE	ACTIVE	Northern CA	PC199G
Health Net of California	Bronze Plus	EE+Spouse, EE+Family	ACTIVE	Northern CA	PC028A
Health Net of California	Bronze Plus	EE+Child(ren)	ACTIVE	Northern CA	PC028B
Health Net of California	Silver	EE	ACTIVE	Northern CA	PC200G
Health Net of California	Silver	EE+Spouse, EE+Family	ACTIVE	Northern CA	PC029A
Health Net of California	Silver	EE+Child(ren)	ACTIVE	Northern CA	PC029B
Health Net of California	Gold	EE, EE+Spouse, EE+Family	ACTIVE	Northern CA	PC030A
Health Net of California	Gold	EE+Child(ren)	ACTIVE	Northern CA	PC030B
Health Net of California	Platinum	EE, EE+Spouse, EE+Family	ACTIVE	Northern CA	PC031A
Health Net of California	Platinum	EE+Child(ren)	ACTIVE	Northern CA	PC031B

Medical Insurance Components of Group Benefit Plan #502: DXC Fully-Insured Employee Welfare Benefits Plan

Carrier	Plan(s)	Coverage Tier	Employee Group	Eligible Geography	Group Number/ Policy Number
Health Net of California	Bronze	EE, EE+Spouse, EE+Family	COBRA	Northern CA	PC027C
Health Net of California	Bronze	EE+ Child(ren)	COBRA	Northern CA	PC027D
Health Net of California	Bronze Plus	EE	COBRA	Northern CA	PC199H
Health Net of California	Bronze Plus	EE+Spouse, EE+Family	COBRA	Northern CA	PC028C
Health Net of California	Bronze Plus	EE+ Child(ren)	COBRA	Northern CA	PC028D
Health Net of California	Silver	EE	COBRA	Northern CA	PC200H
Health Net of California	Silver	EE+Spouse, EE+Family	COBRA	Northern CA	PC029C
Health Net of California	Silver	EE+ Child(ren)	COBRA	Northern CA	PC029D
Health Net of California	Gold	EE, EE+Spouse, EE+Family	COBRA	Northern CA	PC030C
Health Net of California	Gold	EE+ Child(ren)	COBRA	Northern CA	PC030D
Health Net of California	Platinum	EE, EE+Spouse, EE+Family	COBRA	Northern CA	PC031C
Health Net of California	Platinum	EE+ Child(ren)	COBRA	Northern CA	PC031D
Health Net of California	Bronze	EE, EE+Spouse, EE+Family	ACTIVE	Southern CA	N6468A
Health Net of California	Bronze	EE+ Child(ren)	ACTIVE	Southern CA	N6468B
Health Net of California	Bronze Plus	EE	ACTIVE	Southern CA	N6945G
Health Net of California	Bronze Plus	EE+Spouse, EE+Family	ACTIVE	Southern CA	N6469A
Health Net of California	Bronze Plus	EE+ Child(ren)	ACTIVE	Southern CA	N6469B
Health Net of California	Silver	EE	ACTIVE	Southern CA	N6946G

Medical Insurance Components of Group Benefit Plan #502: DXC Fully-Insured Employee Welfare Benefits Plan

Carrier	Plan(s)	Coverage Tier	Employee Group	Eligible Geography	Group Number/ Policy Number
Health Net of California	Silver	EE+Spouse, EE+Family	ACTIVE	Southern CA	N6470A
Health Net of California	Silver	EE+ Child(ren)	ACTIVE	Southern CA	N6470B
Health Net of California	Gold	EE, EE+Spouse, EE+Family	ACTIVE	Southern CA	G0150A
Health Net of California	Gold	EE+ Child(ren)	ACTIVE	Southern CA	G0150B
Health Net of California	Platinum	EE, EE+Spouse, EE+Family	ACTIVE	Southern CA	G0151A
Health Net of California	Platinum	EE+ Child(ren)	ACTIVE	Southern CA	G0151B
Health Net of California	Bronze	EE, EE+Spouse, EE+Family	COBRA	Southern CA	N6468C
Health Net of California	Bronze	EE+ Child(ren)	COBRA	Southern CA	N6468D
Health Net of California	Bronze Plus	EE	COBRA	Southern CA	N6945H
Health Net of California	Bronze Plus	EE, EE+Spouse, EE+Family	COBRA	Southern CA	N6469C
Health Net of California	Bronze Plus	EE+ Child(ren)	COBRA	Southern CA	N6469D
Health Net of California	Silver	EE	COBRA	Southern CA	N6946H
Health Net of California	Silver	EE+Spouse, EE+Family	COBRA	Southern CA	N6470C
Health Net of California	Silver	EE+ Child(ren)	COBRA	Southern CA	N6470D
Health Net of California	Gold	EE, EE+Spouse, EE+Family	COBRA	Southern CA	G0150C
Health Net of California	Gold	EE+ Child(ren)	COBRA	Southern CA	G0150D
Health Net of California	Platinum	EE, EE+Spouse, EE+Family	COBRA	Southern CA	G0151C
Health Net of California	Platinum	EE+ Child(ren)	COBRA	Southern CA	G0151D

Medical Insurance Components of Group Benefit Plan #502: DXC Fully-Insured Employee Welfare Benefits Plan

Carrier	Plan(s)	Coverage Tier	Employee Group	Eligible Geography	Group Number/ Policy Number
Health Net Health Plan of Oregon	Bronze	EE Only	ACTIVE	Oregon	VE986A
Health Net Health Plan of Oregon	Bronze	EE+Spouse, EE+Family	ACTIVE	Oregon	VE986B
Health Net Health Plan of Oregon	Bronze	EE+ Child(ren)	ACTIVE	Oregon	VE986C
Health Net Health Plan of Oregon	Bronze Plus	EE Only	ACTIVE	Oregon	VE987A
Health Net Health Plan of Oregon	Bronze Plus	EE+Spouse, EE+Family	ACTIVE	Oregon	VE987B
Health Net Health Plan of Oregon	Bronze Plus	EE+ Child(ren)	ACTIVE	Oregon	VE987C
Health Net Health Plan of Oregon	Silver	EE Only	ACTIVE	Oregon	VE988A
Health Net Health Plan of Oregon	Silver	EE+Spouse, EE+Family	ACTIVE	Oregon	VE988B
Health Net Health Plan of Oregon	Silver	EE+ Child(ren)	ACTIVE	Oregon	VE988C
Health Net Health Plan of Oregon	Gold	EE, EE+Spouse, EE+Family	ACTIVE	Oregon	VE989A
Health Net Health Plan of Oregon	Gold	EE+ Child(ren)	ACTIVE	Oregon	VE989B
Health Net Health Plan of Oregon	Platinum	EE, EE+Spouse, EE+Family	ACTIVE	Oregon	VE990A
Health Net Health Plan of Oregon	Platinum	EE+ Child(ren)	ACTIVE	Oregon	VE990B

Medical Insurance Components of Group Benefit Plan #502: DXC Fully-Insured Employee Welfare Benefits Plan

Carrier	Plan(s)	Coverage Tier	Employee Group	Eligible Geography	Group Number/ Policy Number
Health Net Health Plan of Oregon	Bronze	EE Only	COBRA	Oregon	VE986D
Health Net Health Plan of Oregon	Bronze	EE+Spouse, EE+Family	COBRA	Oregon	VE986E
Health Net Health Plan of Oregon	Bronze	EE+ Child(ren)	COBRA	Oregon	VE986F
Health Net Health Plan of Oregon	Bronze Plus	EE Only	COBRA	Oregon	VE987D
Health Net Health Plan of Oregon	Bronze Plus	EE+Spouse, EE+Family	COBRA	Oregon	VE987E
Health Net Health Plan of Oregon	Bronze Plus	EE+ Child(ren)	COBRA	Oregon	VE987F
Health Net Health Plan of Oregon	Silver	EE Only	COBRA	Oregon	VE988D
Health Net Health Plan of Oregon	Silver	EE+Spouse, EE+Family	COBRA	Oregon	VE988E
Health Net Health Plan of Oregon	Silver	EE+ Child(ren)	COBRA	Oregon	VE988F
Health Net Health Plan of Oregon	Gold	EE, EE+Spouse, EE+Family	COBRA	Oregon	VE989C
Health Net Health Plan of Oregon	Gold	EE+ Child(ren)	COBRA	Oregon	VE989D
Health Net Health Plan of Oregon	Platinum	EE, EE+Spouse, EE+Family	COBRA	Oregon	VE990C
Health Net Health Plan of Oregon	Platinum	EE+ Child(ren)	COBRA	Oregon	VE990D

Medical Insurance Components of Group Benefit Plan #502: DXC Fully-Insured Employee Welfare Benefits Plan

Carrier	Plan(s)	Coverage Tier	Employee Group	Eligible Geography	Group Number/ Policy Number
Kaiser Foundation Health Plan, Inc.	Bronze, Bronze Plus, Silver, Gold, Platinum	All	ACTIVE, COBRA	Hawaii	50001
Kaiser Foundation Health Plan, Inc.	Bronze, Bronze Plus, Silver, Gold, Platinum	All	ACTIVE, COBRA	Northern CA	604486
Kaiser Foundation Health Plan, Inc.	Bronze, Bronze Plus, Silver, Gold, Platinum	All	ACTIVE, COBRA	Southern CA	232176
Kaiser Foundation Health Plan of Colorado	Bronze	All	ACTIVE	Denver/Boulder Colorado Springs Pueblo Northern Colorado	35646-001 35646-002 35646-004 35646-006
Kaiser Foundation Health Plan of Colorado	Bronze Plus	All	ACTIVE	Denver/Boulder Colorado Springs Pueblo Northern Colorado	35646-007 35646-008 35646-010 35646-012
Kaiser Foundation Health Plan of Colorado	Silver	All	ACTIVE	Denver/Boulder Colorado Springs Pueblo Northern Colorado	35646-013 35646-014 35646-016 35646-018
Kaiser Foundation Health Plan of Colorado	Gold	All	ACTIVE	Denver/Boulder Colorado Springs Pueblo Northern Colorado	35646-027 35646-028 35646-029 35646-030
Kaiser Foundation Health Plan of Colorado	Platinum	All	ACTIVE	Denver/Boulder Colorado Springs Pueblo Northern Colorado	35646-031 35646-032 35646-033 35646-034
Kaiser Foundation Health Plan of Colorado	Bronze	All	COBRA	Denver/Boulder Colorado Springs Pueblo	35646-C01 35646-C02 35646-C04

Medical Insurance Components of Group Benefit Plan #502: DXC Fully-Insured Employee Welfare Benefits Plan

Carrier	Plan(s)	Coverage Tier	Employee Group	Eligible Geography	Group Number/ Policy Number
				Northern Colorado	35646-C06
Kaiser Foundation Health Plan of Colorado	Bronze Plus	All	COBRA	Denver/Boulder Colorado Springs Pueblo Northern Colorado	35646-C07 35646-C08 35646-C10 35646-C12
Kaiser Foundation Health Plan of Colorado	Silver	All	COBRA	Denver/Boulder Colorado Springs Pueblo Northern Colorado	35646-C13 35646-C14 35646-C16 35646-C18
Kaiser Foundation Health Plan of Colorado	Gold	All	COBRA	Denver/Boulder Colorado Springs Pueblo Northern Colorado	35646-C27 35646-C28 35646-C29 35646-C30
Kaiser Foundation Health Plan of Colorado	Platinum	All	COBRA	Denver/Boulder Colorado Springs Pueblo Northern Colorado	35646-C31 35646-C32 35646-C33 35646-C34
Kaiser Foundation Health Plan of Georgia, Inc.	Bronze	EE	ACTIVE	Georgia	10167-S40
Kaiser Foundation Health Plan of Georgia, Inc.	Bronze	EE+Spouse, EE + Child(ren), EE+Family	ACTIVE	Georgia	10167-F40
Kaiser Foundation Health Plan of Georgia, Inc.	Bronze Plus	EE	ACTIVE	Georgia	10167-S41
Kaiser Foundation Health Plan of Georgia, Inc.	Bronze Plus	EE+Spouse, EE + Child(ren), EE+Family	ACTIVE	Georgia	10167-F41

Medical Insurance Components of Group Benefit Plan #502: DXC Fully-Insured Employee Welfare Benefits Plan

Carrier	Plan(s)	Coverage Tier	Employee Group	Eligible Geography	Group Number/ Policy Number
Kaiser Foundation Health Plan of Georgia, Inc.	Silver	EE	ACTIVE	Georgia	10167-S42
Kaiser Foundation Health Plan of Georgia, Inc.	Silver	EE+Spouse, EE + Child(ren), EE+Family	ACTIVE	Georgia	10167-F42
Kaiser Foundation Health Plan of Georgia, Inc.	Gold	All	ACTIVE	Georgia	10167-402
Kaiser Foundation Health Plan of Georgia, Inc.	Platinum	All	ACTIVE	Georgia	10167-403
Kaiser Foundation Health Plan of Georgia, Inc.	Bronze	EE	COBRA	Georgia	10167-S50
Kaiser Foundation Health Plan of Georgia, Inc.	Bronze	EE+Spouse, EE + Child(ren), EE+Family	COBRA	Georgia	10167-F50
Kaiser Foundation Health Plan of Georgia, Inc.	Bronze Plus	EE	COBRA	Georgia	10167-S51
Kaiser Foundation Health Plan of Georgia, Inc.	Bronze Plus	EE+Spouse, EE + Child(ren), EE+Family	COBRA	Georgia	10167-F51
Kaiser Foundation Health Plan of Georgia, Inc.	Silver	EE	COBRA	Georgia	10167-S52
Kaiser Foundation Health Plan of Georgia, Inc.	Silver	EE+Spouse, EE + Child(ren), EE+Family	COBRA	Georgia	10167-F52
Kaiser Foundation Health Plan of Georgia, Inc.	Gold	All	COBRA	Georgia	10167-502
Kaiser Foundation Health Plan of Georgia, Inc.	Platinum	All	COBRA	Georgia	10167-503

Medical Insurance Components of Group Benefit Plan #502: DXC Fully-Insured Employee Welfare Benefits Plan

Carrier	Plan(s)	Coverage Tier	Employee Group	Eligible Geography	Group Number/ Policy Number
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	Bronze, Bronze Plus, Silver, Gold, Platinum	All	ACTIVE, COBRA	Mid-Atlantic States	23067
Kaiser Foundation Health Plan of the Northwest	Bronze, Bronze Plus, Silver, Gold, Platinum	All	ACTIVE, COBRA	Oregon & Parts of Washington	19839
Kaiser Foundation Health Plan of WA Options, Inc.	Bronze	EE Only	ACTIVE, COBRA	Washington	8106900
Kaiser Foundation Health Plan of WA Options, Inc.	Bronze	EE+Spouse, EE+ Child(ren), EE+Family	ACTIVE, COBRA	Washington	8107000
Kaiser Foundation Health Plan of WA Options, Inc.	Bronze Plus	EE Only	ACTIVE, COBRA	Washington	8107100
Kaiser Foundation Health Plan of WA Options, Inc.	Bronze Plus	EE+Spouse, EE+ Child(ren), EE+Family	ACTIVE, COBRA	Washington	8107200
Kaiser Foundation Health Plan of WA Options, Inc.	Silver	EE Only	ACTIVE, COBRA	Washington	8107300
Kaiser Foundation Health Plan of WA Options, Inc.	Silver	EE+Spouse, EE+ Child(ren), EE+Family	ACTIVE, COBRA	Washington	8107400
Kaiser Foundation Health Plan of WA Options, Inc.	Gold	All	ACTIVE, COBRA	Washington	8107500
Kaiser Foundation Health Plan of WA Options, Inc.	Platinum	All	ACTIVE, COBRA	Washington	8107600
Medical Mutual of Ohio	Bronze, Bronze Plus, Silver, Gold, Platinum	All	ACTIVE, COBRA	Ohio	814454001 (multiple)
MCS	Bronze, Silver, Gold, Platinum	All	ACTIVE, COBRA	Puerto Rico	79-791481

Medical Insurance Components of Group Benefit Plan #502: DXC Fully-Insured Employee Welfare Benefits Plan

Carrier	Plan(s)	Coverage Tier	Employee Group	Eligible Geography	Group Number/ Policy Number
(Medical Card System, Inc.) (includes Dental and Vision)					
Priority Health	Bronze, Bronze Plus, Silver, Gold, Platinum	All	ACTIVE, COBRA	Lower peninsula of Michigan	793266
Triple-S Salud, Inc. (includes Dental and Vision)	Bronze, Silver, Gold, Platinum	All	ACTIVE, COBRA	Puerto Rico	SP0005317
UnitedHealthcare Insurance Co.	Bronze, Bronze Plus, Silver, Gold, Platinum	All	ACTIVE, COBRA	U.S. (except Hawaii)	902866
UPMC Health Options, Inc.	Bronze, Bronze Plus, Silver, Gold, Platinum	All	ACTIVE, COBRA	Western Pennsylvania	21229

Dental Insurance Components of Group Benefit Plan #502: DXC Fully Insured Employee Welfare Benefits Plan

Carrier	Plan(s)	Employee Group	Eligible Geography	Group Number/ Policy Number
Aetna Life Insurance Co.	Bronze, Silver, Gold	ACTIVE, COBRA	U.S.	868210)
Cigna Global Health (Dental embedded in Medical plan)	All	ACTIVE, COBRA	Outside of U.S., and in U.S.V.I.	07410A
Cigna Health & Life Insurance Co.	Bronze, Silver, Gold	ACTIVE, COBRA	U.S.	2499864
Cigna Health & Life Insurance Co. (& various regional Cigna entities)	Platinum	ACTIVE, COBRA	Various U.S. regions	2499864
Delta Dental of Virginia	Bronze, Silver, Gold	ACTIVE, COBRA	U.S.	00000600371
Delta Dental of California	Platinum	ACTIVE, COBRA	Various U.S. regions	76996
MCS (Medical Card System, Inc.) (Dental embedded in Medical plan)	Bronze, Silver, Gold	ACTIVE, COBRA	Puerto Rico	79-791481

Dental Insurance Components of Group Benefit Plan #502: DXC Fully Insured Employee Welfare Benefits Plan

Carrier	Plan(s)	Employee Group	Eligible Geography	Group Number/ Policy Number
Metropolitan Life Insurance Co.	Bronze, Silver, Gold	ACTIVE, COBRA	U.S.	0158555
Metropolitan Life Insurance Co. as SafeGuard Health Plans, Inc., a California Corporation	Platinum	ACTIVE, COBRA	California	0158555
Metropolitan Life Insurance Co. as SafeGuard Health Plans, Inc., a Florida Corporation	Platinum	ACTIVE, COBRA	Florida	0158555
Metropolitan Life Insurance Co. as SafeGuard Health Plans, Inc., a Texas Corporation	Platinum	ACTIVE, COBRA	Texas	0158555
Metropolitan Life Insurance Co.	Platinum	ACTIVE, COBRA	NJ (Specialty Care) & NY	0158555
MetLife Health Plans, Inc.	Platinum	ACTIVE, COBRA	NJ (General Care)	0158555
Triple-S Salud (Dental embedded in Medical plan)	Bronze, Silver, Gold	ACTIVE, COBRA	Puerto Rico	SP0005317
UnitedHealthcare Insurance Co. (including United Healthcare Insurance Co. of New York, Dental Benefits Providers of California, Solstice Benefits, Inc., Dominion Dental Services, Inc.)	Bronze, Silver, Gold	ACTIVE, COBRA	U.S.	899784

Vision Insurance Components of Group Benefit Plan #502: DXC Fully Insured Employee Welfare Benefits Plan

Carrier	Plan(s)	Employee Group	Eligible Geography	Group Number/ Policy Number
Cigna Global Health (Vision embedded in Medical plan)	All	ACTIVE, COBRA	Outside of U.S., and in U.S.V.I.	07410A
EyeMed Vision Care[1]	Gold	ACTIVE	U.S.	9921388

Vision Insurance Components of Group Benefit Plan #502: DXC Fully Insured Employee Welfare Benefits Plan

Carrier	Plan(s)	Employee Group	Eligible Geography	Group Number/ Policy Number
EyeMed Vision Care[1]	Silver	ACTIVE	U.S.	9921396
EyeMed Vision Care[1]	Bronze	ACTIVE	U.S.	9921404
EyeMed Vision Care[1]	Bronze, Silver, Gold	COBRA	U.S.	9929878
Metropolitan Life Insurance Company	Bronze, Silver, Gold	ACTIVE, COBRA	U.S.	0158555
MCS (Medical Card System, Inc.) (Vision embedded in Medical plan)	Bronze, Silver, Gold, Platinum	ACTIVE, COBRA	Puerto Rico	79-791481
Triple-S Salud (Vision embedded in Medical plan)	Bronze, Silver, Gold	ACTIVE, COBRA	Puerto Rico	SP0005317
UnitedHealthcare Insurance Company	Bronze, Silver, Gold	ACTIVE, COBRA	U.S.	899784
VSP Vision Care, Inc. (Mid-Atlantic Vision Service Plan, Inc. [Virginia])	Bronze, Silver, Gold	ACTIVE, COBRA	U.S.	30050916

1. Fidelity Security Life Insurance Company dba EyeMed Vision Care

Carrier & Administrator Contact Information

Contact Information: Group Insurance Carriers/Program Administrators (Except Medical, Dental, Vision)

Carrier	Benefit/Program	Phone	Website	Address
Businessolver	DXC Benefits Center COBRA and health & welfare direct billing	1.888.305.5499	myDXCbenefitscenter.com	
The Hartford	Disability Insurance	1.800.523.2233	https://www.thehartfordatwork.com/thaw/	Group Benefits Division, Customer Service P.O. Box 2999 Hartford, CT 06104-2999
Magellan	DXC LifeManagement (EAP)	1.888.696.4272	https://www.magellanascend.com	Magellan Behavioral Health 14100 Magellan Plaza Maryland Heights, MO 63043
Metropolitan Life Insurance Company, “MetLife”	Life Insurance	1.800.638.6420		Metropolitan Life Insurance Co. 200 Park Ave New York NY 10166
Virgin Pulse	Healthy Behaviors Wellness Program	1.855.824.6440	http://member.virginpulse.com/	75 Fountain St Providence, RI 02902
[MetLife]	Flexible Spending Accounts Health Savings Accounts Health Reimbursement Accounts	1.888.305.5499	myDXCbenefitscenter.com	[MetLife contact information to be provided]
Your Spending Account™, “YSA”	Commuter Reimbursement Accounts	1.888.305.5499	myDXCbenefitscenter.com	YSA P.O. Box 640 The Woodlands, TX 77387-4030

Contact Information: Group Insurance Carriers/Program Administrators (Except Medical, Dental, Vision)

Carrier	Benefit/Program	Phone	Website	Address
Zurich American Insurance Company, “Zurich”	Basic and Supplemental Accidental Death & Dismemberment Insurance	1.866.841.4771	http://zurichna.com/	Zurich American Insurance Co. Claims Department P.O. Box 968041 Schaumburg, IL 60196-8041
Zurich American Insurance Co. & Zurich World Travel Protection (provide the DXC policy number when requesting travel assistance GTU-0207327)	Business Travel Accident insurance and Emergency Assistance	1.877.709.7503 (from U.S. or Canada) +1.647.288.2616 (collect from outside U.S. & Canada)	https://www.zurichtravelassist.com	

Contact Information: Medical Carriers

Carrier	Phone	Website	Address
Aetna	1.855.496.6289	https://www.aetna.com	Aetna Attn: National Account CRT P.O. Box 14463 Lexington, KY 40512
Anthem BlueCross Blue Shield	1-844-404-2165	https://www.anthem.com/	Anthem BlueCross BlueShield 2015 Staples Mill Road, Richmond, VA 23230
Cigna	1.855.694.9638	https://my.cigna.com	P.O. Box 188011 Chattanooga, TN 37422
Cigna Global Health (includes Dental and Vision)	1.800.441.2668; or 1.302.797.3100 (collect)	www.cignaenvoy.com	Cigna Global Health Benefits P.O. Box 15050 Wilmington, DC 19850-5050 or 300 Bellevue Parkway Wilmington, DE 19809
Dean/Prevea360	1.877.232.9375	http://aon.deanhealthplan.com/	Dean Health Plan 1277 Deming Way

Contact Information: Medical Carriers

Carrier	Phone	Website	Address
			Madison, WI 53717
Geisinger	1.844.390.8332	https://geisinger.org/member-portal	100 N. Academy Ave Danville, PA 17822-3220
Hawai'i Medical Service Association (HMSA)	1.800.651.4672	https://members.hmsa.com	Hawai'i Medical Service Association (HMSA) P.O. Box 1958 Honolulu, HI 96805-1958
Health Net of California	1.888.926.1692	https://www.healthnet.com/myaon	Health Net Life Insurance Company P.O. Box 10348 Van Nuys, CA 91410-0348
Health Net Plan of Oregon (Oregon & Washington)	1.888.926.1692	https://www.healthnet.com/myaon	Health Net Plan of Oregon P.O. Box 10342 Van Nuys, CA 91410-0342
Kaiser Permanente - California	1.800.464.4000	http://www.kp.org	Kaiser Foundation Health Plan, Inc. P.O. Box 23280 Oakland, CA 94623
Kaiser Permanente - Colorado	1.303.338.3800	http://www.kp.org	Kaiser Foundation Health Plan of Colorado P.O. Box 378066 Denver, CO 80237-8066
Kaiser Permanente - DC, MD, VA	1.800.777.7902	http://www.kp.org	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. 2101 East Jefferson Street Rockville, MD 20852
Kaiser Permanente - Georgia	1.404.261.2590	http://www.kp.org	Kaiser Foundation Health Plan of Georgia, Inc. Nine Piedmont Center 3495 Piedmont Road, NE Atlanta, GA 30305-1736
Kaiser Permanente - Hawaii	1.808.432.5955	http://www.kp.org	Kaiser Foundation Health Plan, Inc. 3288 Moanalua Road Honolulu, HI 96819

Contact Information: Medical Carriers

Carrier	Phone	Website	Address
Kaiser Permanente – Northwest (Oregon, and Vancouver & Longview, Washington)	1.800.813.2000	http://www.kp.org	Kaiser Foundation Health Plan of the Northwest 500 NE Multnomah Street, Suite 100 Portland, OR 97232-2099
Kaiser Permanente – Washington (except Vancouver & Longview area)	1.855.407.0900	https://wa-member.kaiserpermanente.org	Kaiser Foundation Health Plan of Washington Options, Inc. PO Box 34593 Seattle, WA 98124-1593
MCS (Medical Card System, Inc.)	1.888.758.1616	http://www.mcs.com/pr	MCS Grievance & Appeals Unit MCS Plaza PO Box 191720 San Juan PR 00919-1720
Medical Mutual of Ohio	1.800.541.2770	https://member.medmutual.com	2060 E. Ninth Street Cleveland, Ohio 44115
Priority Health	1.833.207.3211	https://member.priorityhealth.com/login	1231 E. Beltline NE Grand Rapids, MI 49525
Triple-S Salud, Inc. (BCBS Puerto Rico)	1.800.810.2583	http://www.ssspr.com	Triple-S Salud, Inc. Departamento de Servicio al Client P.O. Box 363628 San Juan, PR 00936-3628
UnitedHealthcare National	1.888.297.0878	http://myuhc.com	UnitedHealthcare Central Escalation Unit P.O. Box 30573 Salt Lake City, UT 84130-0573
UPMC	1.844.252.0690	https://www.upmchealthplan.com/members	UPMC Health Plan P.O. Box 2999 Pittsburgh, PA 15230-2999

Contact Information: Dental Carriers

Carrier	Phone	Website	Address
Aetna	1.855.496.6289	https://www.aetna.com	Aetna Attn: National Account CRT P.O. Box 14463 Lexington, KY 40512
Cigna	1.855.694.9638	https://my.cigna.com	P.O. Box 188011 Chattanooga, TN 37422
Cigna Global Health (Dental embedded in Medical plan)	1.800.441.2668; or 1.302.797.3100 (collect)	www.cignaenvoy.com	Cigna Global Health Benefits P.O. Box 15050 Wilmington, DC 19850-5050 or 300 Bellevue Parkway Wilmington, DE 19809
Delta Dental (for Bronze, Silver, Gold)	1.877.447.5827	http://www.deltadentalva.com/subscriber.aspx	Delta Dental of Virginia 4818 Starkey Rd Roanoke, VA 24018
DeltaCare USA (for Platinum DHMO)	1.800.471.8073	http://www.deltadentalins.com	Delta Dental Insurance Co. P.O. Box 1860 Alpharetta, GA 30023
MCS (Medical Card System, Inc.) (Dental embedded in Medical)	1.888.758.1616	http://www.mcs.com/pr	MCS Grievance & Appeals Unit MCS Plaza PO Box 191720 San Juan PR 00919-1720
MetLife (Bronze, Silver, Gold plans)	1.888.309.5526	https://www.metlife.com/mybenefits	P.O. Box 14589 Lexington, KY 40512
MetLife Health Plans Inc./Safeguard (Platinum DHMO)	1.888.309.5526	https://www.metlife.com/mybenefits	P.O. Box 3532 Laguna Hills, CA 92654-3532
Triple-S Salud, Inc. (BCBS Puerto Rico) (Dental embedded in Medical)	1.800.810.2583	http://www.ssspr.com	Triple-S Salud, Inc. Departamento de Servicio al Client P.O. Box 363628 San Juan, PR 00936-3628
UnitedHealthcare	1.888.571.5218	http://www.myuhc.com	UnitedHealthcare Dental P.O. Box 30569 Salt Lake City, UT 84130-0569

Contact Information: Dental Carriers

Carrier	Phone	Website	Address
United Healthcare – Platinum in MidAtlantic (DE, DC, MD, PA, VA)	1.888.571.5218	http://www.myuhc.com	Dominion Dental Services 1115 South Union Street, Suite 300 Alexandria, VA 22314

Contact Information: Vision Carriers

Carrier	Phone	Website	Address
Cigna Global Health (Vision embedded in Medical plan)	1.800.441.2668; or 1.302.797.3100 (collect)	www.cignaenvoy.com	Cigna Global Health Benefits P.O. Box 15050 Wilmington, DC 19850-5050 or 300 Bellevue Parkway Wilmington, DE 19809
EyeMed	1.844.739.9837	https://www.eyemedvisioncare.com/member/public/login.emvc	4000 Luxotica Place Mason, OH 45040
MetLife	1.888.309.5526	https://www.metlife/com/mybenefits	MetLife Vision P.O. Box 997100 Sacramento, CA 95899-7100
MCS (Medical Card System, Inc.) (Vision embedded in Medical)	1.888.758.1616	http://www.mcs.com/pr	MCS Grievance & Appeals Unit MCS Plaza PO Box 191720 San Juan PR 00919-1720
Triple-S Salud, Inc. (BCBS Puerto Rico) (Vision embedded in Medical)	1.800.810.2583	http://www.ssspr.com	Triple-S Salud, Inc. Departamento de Servicio al Client P.O. Box 363628 San Juan, PR 00936-3628
UnitedHealthcare	1.888.571.5218	https://www.myuhcvision.com	UnitedHealthcare Vision P.O. Box 30978 Salt Lake City, UT 84130-0978
VSP	1.877.478.7559	https://www.vsp.com/signon.html	VSP P.O. Box 2350

Contact Information: Vision Carriers

Carrier	Phone	Website	Address
(Mid-Atlantic Vision Service Plan, Inc. [Virginia])			Rancho Cordova, CA 95741

ERISA Rights

Your Rights Under ERISA

As a participant in the plans listed above, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Under ERISA, you are entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated summary plan description. The administrator may make a reasonable charge for copies.
- Receive a summary of the plan‘s annual financial report. The plan administrator is required by law to furnish each participant with a copy of the summary annual report or annual funding notice.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, your spouse, or your dependents, if there is a loss of coverage under the plan as a result of a COBRA qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description, the documents governing the plan, and the COBRA information at mydxcbenefits.com/how-cobra-works/ to learn about the rules governing your COBRA continuation coverage rights.
- A reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:
  - You lose coverage under the plan
  - You become entitled to elect COBRA continuation coverage
  - Your COBRA continuation coverage ceases
  - You request the certificate before losing coverage
  - You request the certificate up to 24 months after losing coverage

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months after your enrollment date in your coverage.

Fiduciary Obligations Under ERISA

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan(s):

- The persons who operate the plan(s), called “fiduciaries” of the plan(s), have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.
- No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in a way to prevent you from obtaining a welfare benefit for which you are eligible or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension or welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Generally, DXC Benefits should be able to help you resolve any problems you might have with your right to benefits. Under ERISA, there are steps you can take to enforce your rights. For example:

- If you request a copy of the plan documents or the latest annual report from the plan and do not receive it within 30 days, you may file suit in a federal court. In such case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.
- If you have a claim for benefits which is denied or ignored, in whole or in part; you may file suit in a state or federal court.
- In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court.
- If it should happen that plan fiduciaries misuse plan funds, or you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if the court finds that your claim is frivolous.

If it should become necessary for you or your beneficiary to take legal action to enforce your rights under ERISA or the terms of the plan, DXC‘s agent for service of legal process in all jurisdictions of the United States is CT Corporation System. Service of legal process may also be made upon the plan trustee or plan administrator.

A Final Word About Your Rights

If you have questions about the benefits discussed in this Guidebook, contact DXC Benefits Center. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, contact the:

- Nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or
- Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, Frances Perkins Building, 200 Constitution Ave. N.W., Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline (1.866.444.3272) of the Employee Benefits Security Administration.