U.S. Benefits

How do you benefit?

From selecting what benefit plans are best suited for you to accessing your benefit services, the process can feel somewhat overwhelming. At World Wide Technology, we take pride in being your resource every step of the way by providing you the assistance and support you need. Below you will find answers to commonly asked questions about enrollment and accessing your benefit services.

FREQUENTLY ASKED QUESTIONS

How many days do I have to enroll in my benefits as a new hire?

Eligible employees have 31 days from date of hire to enroll in benefits within Vantage. If you are outside of your 31 days, then you must wait until Open Enrollment or have a qualifying life event and be within 31 days of that event (Birth of a child, adoption, marriage, or loss of external coverage) to make changes.

How many days do I have to change my coverage due to a life event? Can I add my new spouse (from marriage) or new baby (birth of a child) to my health insurance?

Employees have 31 days from the date of the event to report and provide documentation of these types of life events that qualify for mid-year benefit changes. To submit a Life Event, go to **United**> Applications Menu> **Vantage**> Benefits> Report a Qualifying Change.

When do my benefits go into effect as a new hire or after a life event?

Most benefits go into effect the first of the following month after your hire date or the qualified life event. Benefits for birth of children, adoption and loss of external coverage go into effect the same or next day of the event. For additional information on Qualifying Life Events, please view the Qualifying Life Event Options on the WWT Benefits Website.

How do I enroll?

The benefit enrollment system is conveniently located in Vantage. Go to **UNITED (wwt.com)**> App Menu> **VANTAGE**> Benefits > Click Enroll or use the Mobile App. You will be prompted to verify your personal information, add dependents, and enroll in coverages. Click the **Submit** button to proceed and review your final coverage selections. Once elections are confirmed, **save a copy** of your confirmation statement to keep for your records.

Who do I contact if I am not able to enroll in benefits as a full-time employee upon hire?

Please submit a ticket to AskHR and a member of our team will contact you.

When is Open Enrollment?

Eligible employees can make changes to benefits during our annual Open Enrollment. This enrollment period generally occurs each Fall (Early November) for coverage beginning the 1st of the following year. Changes outside of this time frame require a qualified life event and must be submitted within 31 days of that event (Birth of a child, adoption, marriage, or loss of external coverage).

For more information on WWT Benefit Programs and Offerings, including Summary Plan Descriptions, check out the WWT Benefits Website: www.wwt.com/us-benefits.

U.S. Benefits

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Is there an overview of all benefits as a new hire or current employee?

We offer multiple ways to receive benefit overview information:

- For new hires, employees will receive a course in WWT You called “WWT Benefits Resource Guide” that must be completed within 31 days of hire. There is also a brief overview of benefits during Orientation.
- For current employees, our Benefits Guide and Benefits Brochures are available on the WWT Benefits Website. A video is also available on the website.

How does our Health Plan compare to other employers?

We regularly evaluate our Health Plan against other employers, in and out of the Technology industry, to ensure we offer a competitive plan with cost shares that do not cause extreme financial burden to our employees and their family members.

WWT plan copays, deductibles & coinsurance are lower than that of our competitors in the Technology industry. Our actuarial value (richness of our health plan) for the WWT Health Plan is **95%** in the Platinum Plan & **93%** in the Gold Plan as compared to 90% across other companies in the Technology industry. This means for every $100 in health care expenses, WWT pays $95 or $93, depending on your plan!

*Data collected from Willis Towers Watson annual Financial Benchmark Survey. When evaluating “ALL” Companies and not just Technology industry, our competitiveness is more favorable.

401(k)

When can I enroll in the WWT 401(k) Plan?

Employees may enroll in the WWT 401(k) the first of the following month after 3 months of employment. An email is sent from the US Benefits team with instructions on how to set up your account. Example: Hire Date- June 8th, Enroll- October 1st.

When can I rollover my existing 401(K) from my previous employer?

Employees can roll over an existing 401(k) immediately from another company. For additional questions on the Rollover process, please contact Merrill at **800-228-4015** between 8am & 8pm (EST).

When is the 401(k) Employer Match made?

WWT provides a discretionary match, dollar for dollar up to 6% of your eligible compensation contributed to the plan. This match is applied **each pay period**. An annual true up process occurs after the end of the year to ensure that employees who maxed out their 401k prior to year-end receive their full 6% match.

MEDICAL (Excludes HI UHA plan)

What is the difference between the Gold PPO Plan and the Platinum PPO Plan? Which plan is right for me?

Both plans offer the same medical services, copays, deductibles and free preventive care. The only difference between the two plans are the premiums you pay from each paycheck for coverage and the amount you pay after the deductible is met (coinsurance).

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U.S. Benefits

How do you benefit?

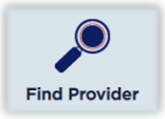
Consider your typical health care experience when deciding which plan to choose:

- The **Platinum Plan** will have higher premiums from each paycheck and covers 100% of in-network medical expenses after the deductible is met. This plan may be right for you if you tend to have high health care costs (surgery, inpatient/outpatient treatment, hospitalization, etc.) or if you prefer to not have a coinsurance after deductible.
- The **Gold Plan** will have lower **premium** amounts from each paycheck but will include a 10% coinsurance. This plan will cover 90% of in-network medical expenses after the deductible is met, up to the out-of-pocket max. This plan may be right for you if you tend to have low health care costs (surgery, inpatient/outpatient treatment, hospitalization, etc.) or if you prefer to have lower premiums than the Platinum plan.

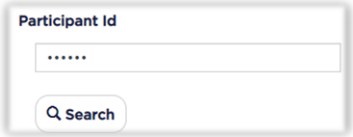
How can I confirm if my health care provider(s) are in the network, Cigna Open Access Plus (OAP), with Allegiance?

Log on to Allegiance's website at www.askallegiance.com and follow the steps below OR call **855-999-3893** if you need assistance.

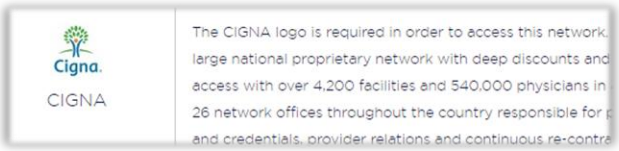
- **Click "Find Provider"**



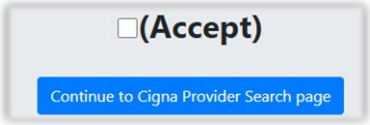
- **Type "Search" in the Participant ID field, click Search & accept the disclaimer**



- **Select Provider Network: Cigna**



- **Click accept to proceed to the Cigna provider search**



- **If presented with a Login screen, choose "Continue as guest" and select "Open Access Plus, OA plus, Choice Fund OA Plus" to search the CIGNA directory of medical providers.**

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U.S. Benefits

How do you benefit?

How do I order or replace my insurance cards? Can I generate a temporary I.D. card?
Newly enrolled individuals will receive new ID Cards in the mail within 10-14 business days. Please watch your mail carefully as these cards may arrive in an unmarked envelope and can appear to be solicitation.

You can also generate a temporary I.D by logging in at www.askallegiance.com and clicking the ID Card tab in the portal or by logging in to the app. If you need to order additional cards or a replacement card, please contact Allegiance by calling **855-999-3893.**

Two I.D. cards will be sent in the original welcome packet. Members can order additional cards, if needed, by contacting Allegiance.

Below is a sample I.D. Card:

How do I instruct my doctor or facility to verify my coverage?
Your doctor or facility can verify active coverage by reviewing your I.D. card. If your doctor or facility is still unable to verify active coverage in the insurance company's system, you can direct your doctor or facility to contact Allegiance at the 24-hour medical coverage verification number listed on the back of your card.

Can I only enroll in medical coverage and decline dental, vision and prescription?
No, the WWT plan is a bundled Health Plan to include all lines of coverage. When you enroll in health insurance you are enrolling in everything: medical, prescription, dental, and vision. You cannot choose to only enroll in one.

Can I add a domestic partner to the Health Plan?
Yes, you may add a domestic partner to the Health Plan at any time but you must complete the Domestic Partner Packet found in the Self Service Portal. Once you submit the Life Event to add your Domestic Partner to coverage, their effective date will be the 1st of the following month. You must provide a

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completed notarized domestic partner packet within 30 days, along with proof that you have lived together for at least 6 months.
IMPORTANT NOTE: Adding a domestic partner to your health plan could have tax implications, and we advise you contact a tax professional to discuss prior to enrolling them in coverage!

Can I utilize the Family Health Center if I am not on the health insurance?
Yes, you do not have to be on the WWT Health Plan to use the Family Health Center as an employee. Dependents may only use the Family Health Center if they are on our Health Plan. You can contact the Missouri Family Health Center at **314-513-1870** and the Illinois Family Health Center at **618-219-7470** for further assistance and to schedule an appointment.

Prescription (Excludes HI UHA plan)

How can I confirm if my Pharmacy is in the network with Express Scripts?
Log on to Express Scripts' website at www.express-scripts.com and click **"Find a Pharmacy"** under Prescriptions from the top menu. For additional coverage management options, **Register** by clicking in the top right corner on the webpage. Once you have registered, you can fully manage your account online.

Will I receive an ID Card separate for Prescriptions?
No, your Health Plan card includes all the details necessary for your Pharmacy coverage.

How do I use my Prescription benefits and what is covered on our plan?
Simply show your Health Plan ID Card which includes the Pharmacy ID information to your pharmacist, and they will submit the script through as a claim on your coverage.
For details on the coverage levels and benefits, please visit the WWT Benefits Website and view the details under Health Insurance.

Where can I get a copy of the Drug Formulary or understand if a specific Medication is covered by our plan?
Log on to Express Scripts' website at www.express-scripts.com and **Register** by clicking in the top right corner on the webpage. Once you have registered, you can fully manage your account online including checking a medication for coverage. Under the **Prescriptions** tab on the top menu bar, choose **Price a Medication**. Your specific plan coverage details will be included and will advise if coverage rules may apply. For additional questions, please call Express Scripts at **888-310-4045**.

Dental (Excludes HI UHA plan)

How can I confirm if my Dentist is in the network under Delta Dental?
Log on to Delta Dental's website at www.DeltaDentalMO.com OR call **800-335-8266** if you need assistance. **Choose Find a Provider in the menu bar at the top of the page and click Find a Dentist.** Please note that Delta Dental operates two different networks – PPO and Premier. The benefit plan with

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U.S. Benefits

How do you benefit?

WWT is the same regardless of which network your dentist participates in. Be sure to check both networks for your dentist's participation.

Will I receive a separate ID Card for Dental?

Yes, Delta Dental will send you ID Cards within 10-14 business days. Please watch your mail carefully as these cards may arrive in an unmarked envelope and can appear to be solicitation.

Cards will be issued in the employee's name only, even in cases where other dependents are enrolled. Providers can easily verify dependents coverage through their provider enrollment records.

What is the difference between the Standard Health Plan Dental and the Dental Buy Up plan?

The Dental Buy Up plan offers employees the option to select a higher level of coverage including Adult Orthodontia and increased Annual Maximum as well as Orthodontia Lifetime Limit.

Dental Buy Up premiums are as follows:

- Employee Only- $2/month
- Employee + Spouse- $5/month
- Employee + Child(ren)- $3/month
- Family- $7/month

Plan Provision	Health Plan Standard Dental	Dental Buy Up
Deductible (Employee/Family)	$50/$150	$50/$150
Annual Maximum	$1,500	$2,000
Preventive/Diagnostic	100%	100%
Basic Services (+Oral Surgery/Endodontics/Periodontics)	80%	80%
Major Services	50%	50%
Orthodontia	50% (Child(ren) only)	50% (all members, including adults)
Orthodontia Lifetime Limit	$1,500	$2,000
See the Dental Buy Up details on the Open Enrollment Website for more information		

For more information on WWT Benefit Programs and Offerings, including Summary Plan Descriptions, check out the WWT Benefits Website: www.wwt.com/us-benefits.

How do I enroll in the Dental Buy Up?

- In the enrollment system, go to the “Medical” tile and click “Change Plan”. Once you have verified your covered family members, click “Select plan” under the plan option showing “with Dental Buy Up”. Save your selection.

IMPORTANT: the Dental Buy Up option is selected on top of the Standard plan and the tier of coverage (Employee Only, Employee + Spouse, Employee + Child(ren), Family) will match your Health Plan selection. The Buy Up Dental plan cannot be selected alone, nor can it be selected in a different coverage tier than the Standard Dental plan.

- You will then see the tile confirming your Dental Buy Up election and the corresponding rate on the main elections page:

- You will also see the Dental Buy Up on the confirmation statement along with the corresponding rate.

Can I select the Dental Buy Up as a stand-alone option with a different tier of coverage than the Health Plan Standard Dental?

No, the Dental Buy Up option is selected on top of the Standard plan and the tier of coverage (Employee Only, Employee + Spouse, Employee + Child(ren), Family) will match your Health Plan selection. The Buy Up Dental plan cannot be selected alone, nor can it be selected in a different coverage tier than the Standard Dental plan.

Vision (Excludes HI UHA plan)

How can I confirm if my Vision provider is in the network with EyeMed?

Log on to EyeMed’s website at www.eyemed.com OR call **866-804-0982** if you need assistance. **Choose “Find an Eye Doctor” at the top of the page and select “Insight Network” when searching for a provider.** EyeMed makes it easy to find an eye doctor with nearly 82,000 in-network providers and members can even schedule an exam online.

For more information on WWT Benefit Programs and Offerings, including Summary Plan Descriptions, check out the WWT Benefits Website: www.wwt.com/us-benefits.

How do I use my Vision benefits and what is covered on our plan?

Simply search for a provider in the network and tell them you have coverage with EyeMed. Id Cards are not required, and providers can search for your coverage in their provider enrollment records.
For details on the coverage levels and benefits, please visit the WWT Benefits Website and view the Vision Benefit Summary under Health Insurance.

Flexible Spending Account (FSA)/Dependent Care

What can I use a Flexible Spending Account for?

Health Care Flexible Spending Accounts can be used for qualified medical expenses such as copays, deductibles, prescriptions, and other qualified health related expenses. Dependent Care FSA funds can be used for daycare, after-school care, and other types of eligible dependent care. For a full list of eligible expenses, see the list on P&A Group's website.

How can I access my FSA account online and submit claims?

When you log into your P&A account at www.padmin.com and enter My Benefits, you will see a summary of your plan(s). Here you can fully manage your account.

Do I have to make a new election each year for Health Care FSA &/or Dependent Care?

Yes, new elections are required to be made each year for Flexible Spending Accounts. Current elections do not carry over each year so it is critical to complete the enrollment process annually if you would like to participate in an FSA.

When do the funds in my flexible spending account expire?

The plan year for this benefit is January 1st -December 31st. If you are enrolled in health or dependent care flexible spending, you can use the funds in your account until the plan grace period of March 15th the following year. After this deadline, all funds will be forfeited per IRS regulations.

Can I change my Health Care FSA/Dependent Care election in the middle of the year (after Open Enrollment)?

Changes are allowed mid-year for qualified life events such as marriage, birth, divorce, etc. However, if a qualified life event is not present, we cannot make changes to an FSA.

Will I receive a Debit Card for my FSA?

Yes, P&A Group sends all enrolled employees a debit card that can be used for point-of-sale expenses. Please watch your mail carefully as these cards may arrive in an unmarked envelope and can appear to be solicitation.

Who do I contact for additional questions about FSA accounts?

P&A customer service team can be reached at **800-688-2611**. When you log into your P&A account at www.padmin.com and enter My Benefits, you will see a summary of your plan(s). Here you can fully manage your account.

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U.S. Benefits

How do you benefit?

Voluntary Life Insurance

What is the maximum amount of voluntary life insurance you can elect for yourself, spouse or child? When can I enroll?

Within the first 31 days upon hire, you are eligible to elect a maximum of $500,000 as the employee, $100,000 for spouse, and $10,000 for child life insurance, of which some amounts may require evidence of insurability. You are guaranteed up to the following amounts as a new hire without providing evidence of insurability: Employee: $300,000; Spouse: $50,000; $10,000 for Child. Employees must select voluntary coverage for themselves before having the ability to add Spouse or Child Life Insurance.

If I did not previously elect Voluntary Life Insurance, or would like to increase my amount to the guaranteed limits, can I do so during open enrollment?

If you currently do not have life insurance and are outside of 31 days of being a new hire, you may select any amount, but you will be requested to submit an evidence of insurability form to be approved for the selected amount. The Evidence of Insurability (EOI) link will be presented in Vantage with the enrollment confirmation for employees to complete. The link to complete EOI remains available in Vantage for 60 days with the new election pending.

If you are currently enrolled, you may increase your amount by up to 2 increments up to the guaranteed amounts during open enrollment: Employee: Up to $20,000, Spouse: Up to $10,000, Children: Up to $10,000.

Spousal Surcharge

What is the Spousal Surcharge?

The Spousal Surcharge is an additional premium amount for those spouses/domestic partners who are offered other employer sponsored health coverage but choose to enroll in the WWT plan instead. This is only applied to those individuals earning $100k or more annually. The surcharge is not added to those whose spouse/domestic partner are not offered other employer sponsored health coverage or spouse/domestic partners who also work at WWT. Eligible employees will be asked to attest to their spouse/ domestic partner's employer health care offering during enrollment.

How much is the surcharge?

The surcharge is $100/month ($50/semi-monthly) and is in addition to your Health Plan premiums.

Who will be required to pay the Spousal Surcharge?

It applies to employees earning $100k or more annually who enroll a spouse/domestic partner, unless one of the following conditions apply:

- Your spouse/domestic partner is not currently employed and does not have access to other employer sponsored health coverage.
- Your spouse is self-employed or employed part-time without access/offer to employer sponsored health coverage.
- Your spouse is covered by Medicare, Medicaid, Tricare/VA or other government sponsored health coverage.
- Your spouse also works for WWT.

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Dependent Verification

Where do I submit my dependent verification documents?
Dependent Verification documents need to be uploaded to Vantage > Benefits > View Verification. If you have any questions about your documents and their status, please call DVS at **800-553-3823.**

How long do I have to complete the dependent verification?
You have 30 days from the date you made your elections in Vantage to submit the required documents.

Additional Information

For additional information on benefits, plan details can be found on the WWT Benefits website www.wwt.com/us-benefits. Employees can also view additional FAQs on the Self Service Portal.

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