WellBeing365
empowering your health every day

FREQUENTLY ASKED QUESTIONS (FAQs)

SAIC®

WellBeing365

What is WellBeing365?

WellBeing365 provides comprehensive benefit options for medical, dental, vision, life, disability insurance and other voluntary benefits. It helps you actively manage your well-being year round, not just during Annual Enrollment. The **WellBeing365 portal** provides information, services and support throughout the year. Personalized support to help you make the best benefits decisions for you and your family is available through the WellBeing365 Service Desk and online chat.

Annual Enrollment

When is Annual Enrollment for 2020?

Annual Enrollment for legacy Engility and legacy SAIC employees will be held October 24, 2019 through November 13, 2019.

When will my elections be effective?

New elections for legacy Engility and legacy SAIC employees will be effective January 1, 2020.

What if I don't enroll during the Annual Enrollment period of October 24 through November 13?

Legacy Engility employees must take action and make new benefit elections for coverage in 2020. Current elections will not carry over into 2020 except for some life and disability coverage and voluntary pet insurance. Medical coverage will default to employee-only coverage under the Core HSA-eligible plan if you have UnitedHealthcare medical coverage in 2019 and you do not take action to elect or waive coverage for 2020.

All legacy SAIC employees should review their benefits, and enroll in or change coverage, if needed. In most cases, current 2019 benefit elections for legacy SAIC employees will carry over, with the exception of health care and dependent care FSA benefits, HSA elections, and Aetna Dental HMO coverage, which is being discontinued.

How do I access the WellBeing365 portal to enroll in my 2020 benefits?

Starting October 24, log on to the **WellBeing365 portal** at **https://wellbeing365.saic.com** and you will be directed to a landing page which will give you the option to connect to the portal.

Confirm your status by clicking on Active Employees or COBRA on the landing page.

- If you are an Active employee and already logged on to the SAIC network, you'll automatically be taken to the **WellBeing365 Portal** home page. Otherwise, you'll first be directed to the SAIC network screen to enter your SAIC login credentials and follow the Multifactor Authentication process (MFA), if applicable. You must have activated your SAIC user account to access the portal and should contact the SAIC IT Service Desk for support, if needed. Then, you will be directed to the **WellBeing365 Portal** home page.
- If you are enrolled in COBRA, you'll be directed to the **WellBeing365 Portal** login screen where you'll enter your login credentials.

Note: When you log in for the first time, you will need to register to create a user name and password.

What if I need help enrolling online?

Starting October 24, you can call the SAIC WellBeing365 Service Desk at 855-798-8686, Monday through Friday, from 8 a.m. to 6 p.m. ET, except holidays. A representative will be glad to assist you in enrolling. You can also refer to the Portal User's Guide in your Annual Enrollment Kit for step-by-step instructions on completing the enrollment process.

When can I start reviewing information online about the 2020 plans and use the online tools and resources available to me?

Starting October 24, you can log in to the **WellBeing365 portal** at **https://wellbeing365.saic.com** to review your 2020 benefit options and use the services and support to help you make your election decisions. Throughout the year, you can use the **WellBeing365 portal** to find information that helps you maintain your health and well-being.

Can I provide access to my spouse to the SAIC WellBeing365 portal?

Yes, from the home page of the **WellBeing365 portal**, select the **My Profile** icon in the upper-right corner > **Login & Recovery** and update the **Spouse/Domestic Partner Site Access** section. You will then receive an email with additional information for your spouse/domestic partner to complete their registration.

Where can I find additional information about Annual Enrollment?

- Refer to the Annual Enrollment Kit mailed to your home in early October which contains the Annual Enrollment Newsletter with rates, the 2020 Benefits Guide and Portal User's Guide.
- Attend an Annual Enrollment briefing in mid-October to mid-November. Refer to the email from Corporate Benefits with the schedule or view the schedule on **www.mysaicbenefits.com**.
- Check your SAIC email and home mailbox for additional communications between now and the end of Annual Enrollment.

What if I need help navigating my plan options?

Beginning October 17, 2019, legacy Engility employees can call Health Advocate at 877-776-6211 for assistance with enrollment. This specialized enrollment advocacy service will be available through the end of Annual Enrollment to assist legacy Engility employees in making confident, informed decisions about their 2020 benefit options. This free service is available from 8 a.m. to 9 p.m. ET, Monday through Friday.

Legacy Engility and legacy SAIC employees can call the WellBeing365 Service Desk with general benefit questions and for assistance in using the **WellBeing365 portal**.

Will I be getting new ID cards for 2020?

Medical and prescription ID cards will be mailed to new participants in December.

The process for obtaining an ID card for dental coverage depends on your dental carrier. If you are enrolled in the Aetna Core or Standard PPO, you will not receive a dental ID card because it is not needed to receive services. If you would like to have a copy of a dental ID card after January 1, log on to the **WellBeing365 portal** and click the link to Aetna's website. You will be able to download or print a copy of a dental ID card.

If you are newly enrolled in the Cigna Standard or Core PPO dental plan, you will receive a dental ID card in the mail.

What's Changing in 2020?

Legacy Engility employees will be moving to WellBeing365, SAIC's benefits program — with new plans and new per paycheck costs — effective January 1, 2020. You must take action and enroll during Annual Enrollment to have benefits coverage in 2020.

Legacy SAIC employees will continue with the WellBeing365 program although there are some changes for 2020 to harmonize SAIC benefits with those of legacy Engility. You must take action during Annual Enrollment to continue your Flexible Spending and Health Savings Accounts in 2020. If you are currently enrolled in the Aetna Dental HMO plan, you will need to select new coverage as the plan is being discontinued.

Employees can review what's changing in their Annual Benefits Enrollment Newsletter provided in the Annual Enrollment Kit mailed to homes. You may also access your newsletter by navigating to the ISSAIC Home page, then go to Pay & Benefits, and Benefits Home under 2020 Annual Enrollment Resources.

This FAQ document does not cover changes to SAIC paid leave or retirement programs. Please refer to the **Benefits Home Page** on ISSAIC and communications sent through email and SAIC News for more details.

What are the changes to the SAIC STD program?

The employer-paid STD benefit will change to 66 2/3 percent of annual base earnings up to $3,202 per week. The seven day waiting period for STD benefits to begin will no longer be waived for hospitalizations of 24 hours or longer. For details, review your Annual Enrollment Newsletter and 2020 Benefits Guide.

What are the changes to the LTD program?

During Annual Enrollment, you have a one-time opportunity to enroll in LTD coverage. After this one-time special enrollment period, you will be subject to evidence of insurability (EOI) to enroll in coverage as a late entrant.

What's New for Legacy Engility?

Which legacy Engility benefit vendors will change in 2020?

Many of the vendors for legacy Engility benefits will be changing. Information about the changing vendors is below:

Benefit	Vendor
Medical	Aetna, Anthem or Cigna depending on your geographic location. Cigna International replaces Aetna International. Kaiser and Voluntary TRICARE Supplement will be offered to eligible employees.
Pharmacy	CVS Caremark replaces Express Scripts for all plans except Kaiser, Cigna International and Voluntary TRICARE Supplement.
Dental	Aetna or Cigna depending on your geographic location.
Flexible Spending Accounts (FSAs) and Health Savings Accounts (HSAs)	BenefitWallet replaces the YSA FSA offering and Optum's HSA.
Employee Assistance Program (EAP)	GuidanceResources by ComPsych replaces Optum.
Life Insurance Coverage	Cigna replaces Hartford.
Long-Term Disability (LTD) Coverage	Cigna replaces Hartford.
Short-Term Disability (STD) Administrator	Sedgwick replaces Hartford.

If I have a HSA today through Optum, what happens to it in 2020?

You have two options to manage your Optum HSA:

- You may choose to keep your HSA through Optum and continue to use it to pay for qualified health care expenses. If you choose this option, you will be responsible for paying all monthly administrative fees and the cost to roll over your account at a later time. You will not be able to contribute to it through payroll deductions in 2020.
- If you open a HSA in 2020 with BenefitWallet, you may roll over your Optum HSA into your HSA account with BenefitWallet. You will be provided rollover instructions in January 2020. In order to roll over your 2019 Optum HSA into a BenefitWallet HSA, you must enroll in a HSA-eligible medical plan for 2020 and open a HSA with BenefitWallet. Additionally, you will receive more information about how to liquidate your investment account, if you have one, and how to authorize the transfer of your Optum HSA to BenefitWallet in early December, provided you open a BenefitWallet HSA during Annual Enrollment.
- You can choose to leave your HSA balance with Optum as an individual account. Note that starting January 2020, you will be responsible for paying all associated fees and arranging for any future contributions that you wish to make, as well as any transfer fees, if you decide to transfer your balance to BenefitWallet at a later date.

What happens if I carry a balance in my FSA (Health Care, Limited Purpose and Dependent Care) as of January 1, 2020, because the vendor is changing from YSA to BenefitWallet?

In order to be reimbursed from your 2019 FSA, all eligible expenses must be incurred by December 31, 2019. You will have until April 30, 2020, to submit the claims incurred in 2019 to YSA for reimbursement from your 2019 FSA. Any unspent balance remaining at the end of the plan year is forfeited.

If you elect a Health Care, Dependent Care or Limited Purpose FSA for 2020, eligible expenses incurred beginning January 1, 2020, must be submitted to BenefitWallet for reimbursement.

Will the legacy Engility wellness program continue?

Beginning February 2020, you will continue to be able to earn wellness incentives by completing health and well-being activities (e.g., biometric screening) and receive SAIC contributions to your HSA (or other rewards if you do not have a HSA) through Rally by Optum. If you contribute to your HSA, it is important for you to review your annual goal and your potential wellness incentives during the year to ensure you maximize the company's wellness contributions.

What happens to my prescriptions at my pharmacy if my coverage is changing from Express Scripts to CVS Caremark?

During Annual Enrollment, you can call CVS Caremark at 844-232-2329 for general questions (with the exception of Cigna International, Kaiser and Tricare) and they will work with you and your doctor to navigate any changes to your prescriptions. If you are filling medications through Express Scripts, you may receive a letter informing you there may be a change to the coverage for your current medication and what steps you can take.

How do I get started with the CVS Caremark mail-order pharmacy beginning January 1, 2020?

Getting started is easy. If you use medication on an ongoing or maintenance basis (such as those used to treat high blood pressure or high cholesterol), you can order up to a 90-day supply and have it delivered to your home — through the CVS Caremark Pharmacy, your mail-order service.

Placing your first order. Visit **www.caremark.com**. Go to the Prescriptions tab and click Start Mail Service.

Receiving your medication. You'll receive your medication within 7 to 10 days after CVS Caremark receives your order.

Requesting refills. When it's time for a refill, you can:

1. Order online at **www.caremark.com**.
2. Call the automated refill system at 844-232-2329. Be sure to have your member ID number and a recent prescription number handy.

If I am currently enrolled in a voluntary benefit do I need to make a new election to continue my coverage in 2020?

Yes. In most cases, you need to re-elect your voluntary benefit to have coverage in 2020. The exception is voluntary pet insurance.

How do I enroll in the commuter benefit program for 2020?

If you wish to take advantage of commuter benefits in 2020, you will need to register for a WageWorks account beginning on November 15, 2019 and make an election for your January commuter benefits by December 6, 2019. Elections made after December 6 will be effective in February 2020. You can link to the WageWorks site on the **WellBeing365 portal** from the scrolling menu at the bottom of the home page.

What happens if I am currently receiving Employee Assistance Program (EAP) support through Optum and the vendor is changing to GuidanceResources through ComPsych?

Employees and their dependents have until December 31, 2019, to request an EAP authorization from Optum and then have 120 days to use their five free visits into 2020.

If I am a legacy Engility employee, how do I view and set my current beneficiary on the WellBeing365 portal?

During Annual Enrollment, log onto the **WellBeing365 portal** and select **Health & Well-being > Health & Well-being**. From there, select the **Beneficiaries** tab, and click **Change** in the blue box. Select the plans for which you want to update beneficiary information, then click **Continue**. Click **Add beneficiary**, then you will see the **Choose Beneficiaries to Display** page. Designate beneficiaries for the selected plan, then click **OK**. You will need to follow the remaining steps to complete your beneficiary designation. Your elections will not save until the **Submitted! You're Done** message appears.

If you have any questions about designating beneficiaries, please call the WellBeing365 Service Desk at 855-798-8686.

Eligibility

Who is eligible to enroll in benefits?

For most SAIC benefits, eligible employees include those who are regularly scheduled to work 30 hours or more per week and are in an eligible fringe benefit package. Note: For Hawaii, employee part-time eligibility is 20-29 hours per week for medical coverage only. If you are covered by a Collective Bargaining Agreement your eligibility for benefits may differ. Legacy Unisys Federal/fringe 25 employees regularly scheduled to work 20 or more hours a week in a benefits-eligible fringe package are eligible.

Are domestic partners considered dependents?

Although domestic partners may not satisfy federal or Internal Revenue Service (IRS) dependent definitions, they are included in SAIC's definition of a dependent. Note that the Voluntary TRICARE Supplement Plan does not permit domestic partners to be covered.

What are SAIC's dependent eligibility requirements for 2020?

An eligible dependent is defined as:

- Your legal spouse or verified domestic partner
- Your children or your verified domestic partner's dependent child under age 26, including:
  - A natural child or stepchild
  - An adopted child (coverage begins on the earlier of the date the child was placed in your home or the date of final adoption)
  - A child for whom you are the full legal guardian. The child must live with you in a parent-child relationship and depend on you for support. You must provide proof of full legal guardianship.
- Your unmarried child, age 26 or older who is not capable of self-sustaining employment because of mental or physical disability as long as the mental or physical disability existed while child was covered under the SAIC Plan and began before age 26, and the child is primarily dependent on you for support.

Note: Voluntary TRICARE Supplement dependent eligibility is based on Voluntary TRICARE eligibility rules.

Will I need to provide documents for dependents I currently have enrolled or only for dependents added during enrollment?

After you enroll, you will be asked to provide documentation only for newly added eligible dependents that you are covering for 2020.

What type of documentation must be submitted for newly added dependents?

You should carefully review SAIC's dependent eligibility guidelines and enroll only qualifying dependents with coverage. You should be prepared to provide documentation once requested. Examples include:

- Proof of Marital Status — redacted tax return or marriage certificate
- Proof of Verified Domestic Partnership — proof of registration with a state or local domestic partner registry, residency document, joint ownership
- Proof of Parent/Child Relationship — birth certificate, hospital record, adoption paperwork, report of birth abroad or legal guardianship document

Why am I required to input my dependent's Social Security number in order to enroll them in medical coverage?

The IRS requires employers to report on individuals covered under a group health plan. This helps the IRS determine if an individual satisfies the individual mandate provision of Health Care Reform. It also helps the IRS determine if an individual is eligible for the premium tax credit. As a result, SAIC is required to collect Social Security numbers (SSNs) from employees and their dependents.

My eligible dependent does not have a Social Security number. Can I still enroll them in coverage?

All dependents over three months old are required to have a Social Security number on file. If your eligible dependent is over three months old and does not have a Social Security number, you should contact the WellBeing365 Service Desk for assistance by calling 855-798-8686.

My dependent child will be turning 26 this upcoming year. When will my child's coverage terminate under the plan?

Eligible children can be covered under your plan until they attain age 26. Medical, dental, vision and child life insurance coverage will terminate at the end of the month in which your child turns 26.

When can I make changes to my benefits after Annual Enrollment?

Outside of Annual Enrollment, the IRS requires that employees be allowed to change their benefit elections during the plan year only after experiencing a qualified life event. If you do, then you have 31 days following the event to make a benefit election change that is consistent with the qualified life event you experienced.

A qualified life event may include, but is not limited to:

- Marriage, legal separation, divorce
- Birth, legal adoption, placement of a child for adoption
- Death of a spouse/domestic partner or dependent child
- Change in employment status that impacts coverage eligibility
- Loss of coverage under another employer's group benefit plan
- Change in a dependent's status that impacts benefit coverage

Services & Support

Where can I learn more?

The **WellBeing365 portal** at **https://wellbeing365.saic.com** includes tools and resources to help you make informed decisions. Two helpful tools during Annual Enrollment are the Find a Provider Lookup tool and the Plan Comparison tool. Both are accessible in step 3 of the annual enrollment event. You also have the support of the WellBeing365 Service Desk by calling 855-798-8686.

When should I contact the WellBeing365 Service Desk?

For eligibility and general benefit questions, you should contact the WellBeing365 Service Desk.

For questions regarding medical, dental or vision claims, you should first contact the insurance provider by calling the number on the back of your card or Health Advocate at 877-776-6211, which can provide advocacy on your behalf.

How do I update my address?

Update your home address on ISSAIC by accessing myHR on the **ISSAIC** home page, left navigation myHR title.

General Medical

Where can I locate a common list of insurance terms?

You can locate a list of common insurance terms on the **WellBeing365 portal** (Health and Well-being > Health & Well-being > More > Tools > Health & Well-being Glossary Tools).

Is preventive care covered at 100 percent?

Yes, preventive care will be covered at 100 percent for all medical and dental plans.

How do I take advantage of the telemedicine option to confer with a doctor about a minor medical ailment?

Visit the website of the carrier for your medical plan, Aetna, Anthem, Cigna or Kaiser, set up or log on to your account and request a phone or video consultation.

What is a "Select Network" plan?

The Select Network plans have a smaller network of in-network providers and will be offered by either Aetna or Cigna depending on where you live. Please note, Anthem does not offer Select Network plans. While the plan designs are the same as the Broad Network plans, the Select Network plans consist of smaller in-network provider networks and these providers have agreed to deeper discounts on their services resulting in a lower premium cost to you as compared to the Broad Network Plans. These plans will be called PPO–Select Network, Premium–Select Network, Standard–Select Network and Core–Select Network.

How does the Broad Network differ from a Select Network?

A Broad Network refers to a provider group with a wide array of in-network doctors. An insurance carrier's Select Network differs from its Broad Network by including fewer, in-network providers that have agreed to deeper discounts, resulting in a 7 percent discount from the Broad Network plans. All Select Network providers have met the same rigorous quality-of-care and treatment outcome standards as the Broad Network providers.

Will my doctor be available in the Select Network?

It depends. Use the Find a Provider Lookup Tool on the **WellBeing365 portal** to ensure that your doctor is an in-network provider. If they are not an in-network provider, you may have to consider choosing a new doctor or pay the higher costs associated with using an out-of-network provider.

What happens if I enroll in a Select Network plan and later move out of the service area for that plan?

The Select Network plans are only available in certain geographic regions. If you enroll and later move to a new location outside of the service area of your chosen plan, this will trigger a new enrollment option.

If you are enrolled in the Aetna or Cigna Select Network plan and you leave the network service area, and there is not an Aetna or Cigna Select Network plan in your new service area, the default enrollment will be to remain in the same carrier's Broad Network plan in your new home location for the balance of the calendar year. Your premiums will increase 7 percent consistent with the increased cost for the Broad Network plans. However, any expenses incurred toward your deductible and out-of-pocket maximums will continue to apply to the Broad Network plan through the end of that calendar year. You will also be permitted to change your election as follows:

- You can enroll in the same carrier's additional Broad Network plans that are less expensive than your current plan.
- You can change your coverage tier (meaning employee only, employee plus family, etc.).
- You can waive medical coverage.

For the Broad and Select Network plan, what happens if a covered adult child lives out of state?

Under the Broad network, regardless of the reason, access to coverage travels with you and your family wherever you go. Nationwide in-network coverage is available whether you're with Anthem, Aetna or Cigna. To locate a network provider in your area, call the customer service number on the back of your ID card or visit your health insurance carrier's website and click "Find a Doctor". You may also contact Health Advocate at 877-776-6211 Monday through Friday, 8 a.m. to 10 p.m. ET.

Under the Select Network, the participant must use a provider within the Select Network in order to receive in-network coverage. If there is not a Select Network provider available in the area, contact your carrier directly to find out what in-network providers are available.

Transition of Care

What is Transition of Care?

If you are a legacy Engility employee changing carriers in 2020 or a legacy SAIC employee that may have a carrier change in 2020, you may be able to continue to receive services at in-network levels for specified medical and behavioral conditions from providers who do not participate in your 2020 carrier's network. Examples of such conditions are:

- Pregnancy
- Treatment for an active behavioral health condition
- Acute or serious medical conditions

Each carrier's provisions for transition of care differ, such as the time that you are required to submit for transition of care after the effective date of your new carrier's coverage. Transition of care is subject to medical review by your current carrier.

What if I am currently receiving medical, dental or vision care for a particular condition or procedure, such as a surgery, toward the end of 2019 that runs into 2020? How will the new coverage in 2020 impact me?

If you are in the middle of specific treatment in 2019 that may require continuing care under the same provider in 2020, options to continue your treatment may be available to you. Health Advocate is available at no cost to you to provide you an overview of your options for continued treatment, so that you can make an informed decision for you and your family. Services are completely confidential.

You can access Health Advocate during their business hours, Monday through Friday, from 8 a.m. to 10 p.m. ET. Simply call 877-776-6211 to talk to a personal health advocate.

How do I know if my current doctors will be in-network for my new benefit options for 2019?

Beginning October 24, log on to **https://wellbeing365.saic.com** and use the Find a Provider Lookup Tool to see if your current medical or dental providers are in-network for 2020.

What should I do if I am in the process of receiving an ongoing orthodontia treatment, crowns, etc. that may extend into 2020 (applies to legacy Engilty employees and to legacy SAIC employees losing coverage under the Aetna Dental HMO plan)?

If you are in an active course of orthodontia treatment and receiving benefits under your existing dental plan coverage, your orthodontia installments may continue if you enroll in an Aetna or Cigna dental plan that covers orthodontia services. However, you should contact your plan to verify specific timeframes and guidelines for coverage.

If you are in an active course of treatment for dental implants, crowns, etc. and receiving benefits under your existing dental plan coverage, contact Health Advocate.

The PPO Plan

With family coverage, how do the family deductible and out-of-pocket maximum work under the PPO Plan?

While many services under the PPO Plan require a copayment, there are some services where the deductible must be met before the plan begins paying for the covered care. For these types of services, you and your dependents have to meet the entire family deductible before the plan begins paying for these services. The out-of-pocket maximum provides protection, limiting your total out-of-pocket costs for a given year. Copayments and your deductible all apply toward the out-of-pocket maximum. The individual deductible and out-of-pocket maximum applies to employee-only coverage. If you enroll one or more dependents, the family deductible and out-of-pocket maximum will apply. Remember, age and gender-appropriate in-network preventive care is covered at 100 percent and is not subject to the deductible.

The individual out-of-pocket maximum is embedded into the family out-of-pocket maximum. This means that once a covered member meets the individual out-of-pocket maximum, any eligible expenses incurred by that member throughout the remainder of the plan year will be covered by the plan at 100 percent, regardless of whether the entire family out-of-pocket limit has been met.

How much will it cost for me to go to the doctor?

Under the PPO Plan, in-network preventive care, such as physicals, mammograms and immunizations, are covered at 100 percent. Each doctor office visit that does not qualify as preventive care is subject to a copayment fee at the time of service — $20 for a primary care physician (PCP) and $40 for a specialist. Any further medical treatment is subject to the annual deductible, and then the plan pays the majority of the cost for non-preventive care. Your in-network cost share, or coinsurance, is 10 percent under the PPO Plan. If you have enrolled in a Health Care FSA, you can use those pre-tax funds to pay for out-of-pocket health care expenses, including the deductible.

Review the **WellBeing365 portal** at **https://wellbeing365.saic.com** for more information on the PPO Plan and how it pays for covered care (e.g., an emergency room visit is subject to a $100 copayment, then after the deductible is met, a 10 percent coinsurance charge).

How can I find out if my doctor is in the network?

Starting October 24, you can access the network directory from the Find a Provider Lookup Tool, located on the **WellBeing365 portal** at **https://wellbeing365.saic.com**.

Where can I find the 2020 rates for the PPO plan?

You can see the rates for all plans available in your service area when you log in to the **WellBeing365 portal** or by reviewing your 2020 Annual Enrollment Newsletter on the **Benefits page** on ISSAIC.

HSA-Eligible Plans

How do the family deductible and out-of-pocket maximum work under the Premium, Premium-Select Network, Standard, Standard-Select Network, Core and Core-Select Network medical plans?

You and your dependents have to meet the entire family deductible before the plan begins paying for any covered care that is not considered routine preventive. The out-of-pocket maximum provides protection, limiting your total out-of-pocket costs for a given year. The individual deductible and out-of-pocket maximum applies to employee-only coverage. If you enroll one or more dependents, the family deductible and out-of-pocket maximum will apply. Remember, age and gender-appropriate in-network preventive care is covered at 100 percent and is not subject to the deductible.

The individual out-of-pocket maximum is embedded into the family out-of-pocket maximum. This means that once a covered member meets the individual out-of-pocket maximum, any eligible expenses incurred by that member throughout the remainder of the plan year will be covered by the plan at 100 percent, regardless of whether the entire family out-of-pocket limit has been met.

How much will it cost for me to go to the doctor?

Under all HSA-eligible plans, in-network preventive care, such as physicals, mammograms and immunizations, is covered at 100 percent.

After you meet the annual deductible, the plans pay the majority of the cost of a doctor visit, but at different levels for the three HSA-eligible plans. Your in-network cost share, or coinsurance, is 20 percent under the Premium Plan; 25 percent under the Standard Plan and 30 percent under the Core Plan. You will need to meet the deductible for all non-preventive care before a plan pays (including prescriptions). If you have enrolled in the HSA, you can use those pre-tax funds to pay for out-of-pocket health care expenses, including the deductible. Use the Plan Comparison Tool when you enroll on the **WellBeing365 portal** to review information on the plans and how they pay for covered care. On the “Things to Review” page, you can “View Benefit Options” to see costs and a Summary of Benefits and Coverage for eligible plans.

How can I find out if my doctor is in the network?

Beginning October 24, you can access the network directory by using the Find a Provider Lookup Tool, located on the **WellBeing365 portal** at **https://wellbeing365.saic.com**.

Where can I find the 2020 rates for the HSA-eligible plans?

You can see the rates for all plans available in your service area when you log in to the **WellBeing365 portal** or by reviewing your 2020 Annual Enrollment Newsletter on the **Benefits page** on ISSAIC.

Health Savings Account (HSA)

How does a HSA work?

When you first enroll in any HSA-eligible plan, you have the option to open a HSA through BenefitWallet. You can contribute pre-tax dollars to the HSA up to the annual IRS contribution limit. You can use the HSA to pay for eligible health care expenses — tax free! Once your HSA balance reaches $1,000, you can also invest and grow your HSA savings for future health care expenses, including those after you retire.

Who is eligible to open or contribute to a HSA?

You must be enrolled in a HSA-eligible plan (Premium, Standard or Core) to be eligible for a HSA. You cannot be claimed as a dependent on anyone else's tax return, covered by any other plan that is not considered a HSA-eligible plan, such as Voluntary TRICARE, your spouse's HMO, POS or PPO medical plan, Medicare Parts A or B or a Health Care FSA. If you are an otherwise HSA-eligible veteran with a disability rating from the VA, you remain HSA-eligible (see IRS Notice 2015-87 question 20 for additional information).

What can I use the HSA for?

Use the HSA to pay for eligible health care expenses. Go to **www.mybenefitwallet.com** for a list of eligible HSA expenses. This includes medical and prescription drug expenses, as well as dental, vision and other expenses that qualify as tax-deductible through the IRS but aren't paid by the health plan.

What are the tax advantages of a HSA?

HSAs are unique in that you can set aside money in your HSA on a pre-tax basis, up to an annual limit (see "How much can I contribute to my HSA" FAQ below). Your money grows tax-free, and when your balance reaches $1,000, you can invest and grow your HSA dollars tax-free in a mutual fund to help meet your future health care expenses, even after you retire. Finally, you can pay eligible health care expenses using tax-free HSA dollars. That's a triple tax advantage! Please note this tax treatment is for federal taxes and varies by state.

How can I open a HSA?

BenefitWallet administers the HSA and partners with BNY Mellon, the account custodian. If you are enrolled in any of SAIC's HSA-eligible plans, a HSA will need to be opened during the benefits enrollment process if you don't already have a HSA open with BenefitWallet.

How much can I contribute to my HSA in 2020?

In 2020, you can make pre-tax contributions from your pay up to $3,550 for individual coverage and $7,100 if you enroll a dependent under one of the family coverage tiers.

If you will be age 55 or older in 2020, you can make an additional $1,000 in catch-up contributions during the year. You can elect to have this amount deducted via pre-tax payroll deductions.

Do I have to use the money in my HSA first or can I choose to pay my deductible out of my own pocket?

The decision to use your HSA or pay with other money is yours each time you receive health care. If you do not use all the funds in your HSA by the end of the year, any unused balance rolls over to the next year. You own all contributions made to your HSA, even if you terminate employment with SAIC. This means any unused dollars can be used for eligible health care expenses in future years, even during retirement.

Flexible Spending Accounts (FSAs)

Eligible Expenses

Where can I get a list of eligible expenses that apply to the FSA?

You can review the list of eligible expenses for Health Care and Dependent Care FSAs by visiting **www.mybenefitwallet.com**.

Are over-the-counter (OTC) drugs and supplies eligible expenses under the Health Care FSA?

You can receive reimbursements for OTC drugs, as long as you have a doctor's prescription. Medical devices and supplies (crutches, blood sugar monitors, etc.), and items such as bandages, contact lens solution or denture bond do not require a doctor's prescription to be reimbursed.

If OTC drugs require a prescription, does this mean that I have to schedule a doctor's appointment and pay for an office visit just to get reimbursed for my OTC drug?

Requiring an office visit for an OTC drug prescription is determined between the patient and the provider. An office visit may be required if it is a new illness not previously treated by the doctor. You should contact your health care provider to determine what policy the provider has in place to accommodate the prescription requirement to be reimbursed for OTC drugs.

What's the age limit for eligible dependents under the Dependent Care FSA and what can it be used for?

The Dependent Care FSA is a pre-tax benefit account used to pay for dependent care services, such as preschool, summer day camp, before- or after-school programs and child or elder day care. Your dependent must be a qualified tax dependent under age 13 or a disabled dependent, of any age, that requires care because of a physical or mental incapacity.

Are OTC weight-loss items eligible?

Yes. However, you will need to submit a doctor's statement with your reimbursement request verifying that the patient's diagnosis is obesity and that the OTC item was prescribed to treat obesity. Keep in mind, a FSA will not pay for the cost of food supported by a weight-loss program.

What is a Letter of Medical Need or Doctor's Statement?

The IRS requires that medical expenses reimbursed through a FSA must be primarily for the diagnosis, treatment or prevention of disease. For example, your doctor may prescribe a vitamin to treat your medical condition. Because vitamins are generally considered an ineligible OTC expense, you will need a letter from your medical provider detailing the type of service rendered and the treatment necessary to be reimbursed.

What is a Limited Purpose FSA?

A Limited Purpose Flexible Spending Account (LPFSA) allows you to use pre-tax dollars to pay for eligible out-of-pocket dental and vision expenses. LPFSAs are typically paired with a HSA, allowing you to maximize your tax savings. Your LPFSA is subject to the IRS "Use-or-Lose" rule, meaning the IRS requires you to forfeit any unspent funds at the end of the plan year.

How do a LPFSA and the HSA work together?

If you have a HSA, then you can also use a LPFSA to pay for eligible dental and vision expenses (rather than use your HSA funds). You can also use your LPFSA for medical and prescription drug expenses, after you meet the annual deductible for your HSA-eligible medical plan coverage.

Note: If you have a LPFSA and you meet the annual deductible for your HSA-eligible plan, contact BenefitWallet to find out what you will need to provide to begin using your LPFSA for eligible medical and prescription drug expenses.

Will I get a new Health Care FSA or HSA debit card for 2020?

Yes. If you newly enroll in a Health Care FSA or a Health Savings Account for the first time in 2020, you will receive one debit card from BenefitWallet. You can request additional debit cards online or by calling the BenefitWallet Service Center at 855-214-9793.

Claim Information

What website do I use for claims reimbursement?

If you are a legacy SAIC employee and elected a 2019 FSA, submit all eligible FSA claims incurred in 2019 (i.e., claims under your 2019 Health Care FSA, Limited Purpose FSA or Dependent Care FSA) to BenefitWallet at **www.mybenefitwallet.com**. Legacy Engility employees must submit 2019 claims to YSA by April 30, 2020. Any unspent balance remaining at the end of the plan year is forfeited.

What are the essential things I need to know about managing my FSA?

FSAs are plans governed by IRS regulations which determine who is eligible to use the account and what, where and how the money can be used. It is your responsibility to:

- Make sure account funds are spent only on eligible expenses for you and your eligible tax dependents. A list of eligible expenses can be found on the BenefitWallet page on the **WellBeing365 portal.**
- Keep your itemized receipts and make sure the service, the amount you paid and the service date (not payment date) are included. You can also keep the explanation of benefits (EOB) statements received from the carrier to substantiate your Health Care FSA expenses.
- Keep track of your FSA balance by reviewing your online statement. In some cases, you may be required to submit additional information regarding debit card transactions or claims submitted.

What are the minimum and maximum amounts you can contribute to a Health Care FSA in 2020? A Dependent Care FSA? A LPFSA?

- The minimum contribution for any FSA is $100.
- The maximum amount you can contribute to your Health Care or LPFSA in 2020 is $2,700.
- The maximum contribution limit for the Dependent Care FSA is $5,000 (per household).

Reimbursements

Will I receive reimbursement through my paycheck?

No. To receive reimbursements via direct deposit, you can register at **www.mybenefitwallet.com** and provide them with your financial account information.

Does a Health Care FSA reimburse for only the enrolled participant's health care expenses or will it reimburse for other family members as well?

A Health Care FSA will reimburse you for health care expenses incurred by you and your eligible tax dependents, even those not covered under our health and well-being plans. Likewise, if you are covered under a spouse's medical plan rather than an SAIC health plan, you can still use SAIC's FSA benefit to reimburse you for your tax dependents' health care expenses. If your spouse also participates in his/her Company's FSA plan, you cannot both be reimbursed for the same eligible expense.

How is my Health Care FSA funded?

Once your benefits take effect, your account will be funded with your total annual election amount. Throughout the year, the annual election amount will be deducted from your paychecks in equal, pro-rata amounts.

Do I have access to my entire Dependent Care election amount at the beginning of the year?

No. You will have access only to the cumulative dependent care funds that have been deducted from your paycheck each pay period during the year. Under the "Use-or-Lose" rule, the IRS requires you to forfeit any unspent funds at the end of the plan year.

What if I have money left in my FSA account at the end of the year?

The IRS-mandated "Use-or-Lose" rule applies and you forfeit any funds that are not claimed by the end of your coverage period.

What is the deadline for submitting a reimbursement request?

You can submit a reimbursement request at any time during the same plan year when the expense was incurred. Otherwise, you will have a deadline date of four months after the plan year to submit for reimbursement, or by April 30 of the following year.

What ways can I receive reimbursement?

There are three options for receiving reimbursement:

Use your health care debit card	Visit the health care debit card FAQs for more information. **Note:** Cannot be used for dependent day care expenses.
Pay My Provider	You can request BenefitWallet to pay your provider directly by following the instructions on **www.mybenefitwallet.com**.
Pay Me Back	You can file a claim online. You can also upload your receipts online. OR You can download a claim form and fax or mail your claim form to BenefitWallet. Fax number: 877-841-1152 Mail to: BenefitWallet, P.O. Box 18009, Suite A, Norfolk, VA 23501

How do I receive my reimbursements by direct deposit?

You may sign up for direct deposit online after you register with the BenefitWallet member portal. After logging into your online account at **www.mybenefitwallet.com**, just hover over your name displayed at the top right of the page. Click on Direct Deposit Information and enter the routing number and account number for your personal checking or savings account. This account number can be changed at any time.

Enrollment and Contact Information

Is a Health Care FSA completely separate from medical and dental benefits?

Participation in a Health Care FSA is in no way linked to participation in medical and/or dental plans.

If I have a baby in the middle of 2020, will I be eligible to enroll in a Dependent Care FSA at that time?

Yes. The birth of a child is a qualified life event and you can enroll at that time.

Can I change my election if I use up all the funds in my account before the end of the year?

No. You can only change the amount you are contributing if you have a qualified life event, such as a change in marital status or the birth of a child.

What is the difference between a Health Care Flexible Spending Account and a Health Savings Account?

Health Care Flexible Spending Account (FSA)	You elect to set aside a certain amount of money pre-tax from which you can reimburse yourself for certain out-of-pocket expenses. Health premiums cannot be reimbursed. Unused funds are subject to "Use-or-Lose" provisions. **You may not take unused funds to a new employer.**
Health Savings Account (HSA)	A HSA is available only with a HSA-eligible plan, including the Premium, Standard and Core; and Premium-Select Network, Standard-Select Network and Core-Select Network Plans. You can adjust your HSA contributions any time. The account is owned by you and can earn interest or be invested. Eligible expenses can be reimbursed. Non-qualified withdrawals can be made, but are subject to taxation plus a penalty. After age 65, death or disability, there's no penalty. **Unused funds from the account roll over from year to year and are fully portable —you can take them to a new employer.**

Note: You cannot enroll in the Health Care FSA if your spouse is enrolled in a HSA in the same plan year but you may enroll in the Limited Purpose FSA.

What if I leave the Company during the year and still have money in my Health Care FSA?

You will be reimbursed for any eligible expense incurred before the date you leave the Company.

Any remaining funds in the account must be forfeited. Any expenses you incur after the end of your employment are not eligible for reimbursement unless you are eligible and elect to continue your Health Care FSA via COBRA.

Can I use the Dependent Care FSA and also claim the federal tax credit for dependent care expenses?

Whether the Dependent Care FSA or the tax credit is more advantageous to you depends on your personal tax situation. You should consult your tax advisor.

Whom do I contact for FSA questions?

If you can't find your answer online on **www.mybenefitwallet.com**, call BenefitWallet Service Center at 855-214-9793, for assistance Monday through Friday, from 8 a.m. to 11 p.m. ET; Saturday and Sunday, 9 a.m. to 6 p.m. ET.

Health Care Debit Card

I received my health care debit card. What do I do?

Call the BenefitWallet automated system to activate your card. The phone number is provided on a sticker attached to your card. Follow the instructions during the automated call. If you need additional cards or help activating, call the BenefitWallet Service Center at 855-214-9793.

How do I use my health care debit card?

Your BenefitWallet health care debit card is only for use at select pharmacies, health care providers and general merchandise stores that have an IRS-approved inventory and checkout system (IIAS). In most instances, your card transaction will be automatically verified at checkout, which means you will not have to submit a receipt to BenefitWallet after the transaction to substantiate it.

You are, however, required to keep each receipt for tax purposes in the event it is needed for verification. When you go to one of these stores or provider's office and swipe your card, choose credit, even though your health care debit card is not a credit card.

What is IIAS?

IIAS is the common acronym for the IRS-approved Inventory Information Approval System. IIAS was introduced in 2008 and enables participating merchants to verify card purchases right at the check-out counter. Because all stores (including pharmacies and drug stores) that sell general merchandise along with health care items must participate to accept the card, it helps eliminate the need and hassle of having to submit receipts to substantiate the transaction after the purchase.

Do I need to submit receipts if I make a purchase at a merchant with an IIAS?

No. You will not need to submit receipts if the merchant has an IIAS. Only eligible health care items can be purchased with the card at the point of sale. BenefitWallet will substantiate these card transactions.

If I use my health care debit card to pay for my visit at the doctor's office, will I need to submit receipts?

Please save all your receipts and monitor your account on BenefitWallet's member portal. When you use your health care debit card at a doctor's office, BenefitWallet will attempt to substantiate your card transaction automatically. If they are not able to do so, you will be asked to submit an itemized receipt, or an explanation of benefits (EOB) from the carrier to substantiate the transaction.

If I have a letter of medical necessity to purchase a non-eligible OTC item, will I be able to pay for it with a health care debit card?

The IIAS will only allow the standard list of eligible OTC items to be purchased via the card. Any items that are not on this list will require a letter of medical necessity and will need to be paid for with another form of payment and reimbursed via a BenefitWallet Claim Form.

Do I have to use the health care debit card for my expenses or are there other options?

No, you do not have to use the debit card. You also can file a claim online to request reimbursement for your eligible expenses.

Kaiser, Voluntary TRICARE Supplement and Cigna International Plan Options

How can I obtain in-depth information on Kaiser and the Cigna International Plans?

Certificates of Coverage and Benefit Summaries for 2020 are available on the **WellBeing365 portal** at **https://wellbeing365.saic.com**.

Why are the Cigna International medical and dental plans the only options available to employees on long-term overseas assignment?

Medical and dental coverages must comply with the changing international health care regulations, as well as provide you with adequate coverage while you are in an overseas assignment. In order to ensure access to quality care and compliance with international regulations, you will be offered medical and dental coverage only through the Cigna International Plan.

Does the Cigna International Plan cover my eligible dependents?

Yes. The Cigna International Plan provides coverage for you and your dependents whether they reside overseas or remain stateside.

How can I locate an in-network provider for the Cigna International Plan?

You can locate an in-network provider online at **www.CignaEnvoy.com**. Cigna International Plan services that are obtained overseas are paid at the in-network level of coverage. Therefore, employees and their family members who live and obtain services overseas are covered at the in-network percentage regardless of the physician they use.

I am enrolled in the Cigna International Plan, but receive my health care stateside. If I meet my in-network deductible of $1,000 and then go to a non-network provider, do I have to pay another $2,000 deductible?

No. If you have already met your in-network deductible of $1,000, you will be required to pay only an additional $1,000, for a total deductible paid of $2,000.

How do I know if I am eligible to enroll in the Voluntary TRICARE Supplement Plan?

You must be enrolled in TRICARE to be eligible to enroll in the Voluntary TRICARE Supplement Plan offered by SAIC. If you are covered under TRICARE Reserve Select and you are not already enrolled in the TRICARE Supplement plan, you should not enroll in the Voluntary TRICARE Supplement plan as it is not open to new entrants with TRICARE Reserve Select coverage.

What are my options for dental and vision coverage if I am enrolled in Voluntary TRICARE?

You may enroll in dental and vision coverage at SAIC if you are benefits eligible. You do not have to be enrolled in a medical plan to enroll in the dental and vision coverages.

You may also want to review the dental and vision coverage options offered by the Federal Employees Dental and Vision Insurance Program (FEDVIP) that are available to those enrolled in Voluntary TRICARE. FEDVIP vision coverage is offered to retired uniformed service members and their families who were eligible for Voluntary TRICARE Retirement Dental Program (TRDP), and who are enrolled in a Voluntary TRICARE health plan.

Where can I find more information on the FEDVIP dental and vision plans for 2020?

Visit **www.benfeds.com** for more information. Open Season starts November 11, 2019.

Supplemental Medical Benefits

What are voluntary supplemental medical benefits?

SAIC offers Critical Illness Insurance, Accident Insurance and Hospital Indemnity Insurance. You are responsible for the entire, after-tax premium cost when you elect any voluntary supplemental medical benefit.

What is Critical Illness Insurance?

This benefit provides a lump-sum benefit if you are diagnosed with a covered critical illness (e.g., heart attack, stroke, cancer, major organ transplant).

What is Accident Insurance?

Accident Insurance provides cash benefits to help you with out-of-pocket expenses associated with a covered accidental injury.

What is Hospital Indemnity Insurance?

This benefit provides financial assistance if you're hospitalized for pregnancy, illness or injury after coverage is effective.

Are the Accident Insurance, Critical Illness Insurance and Hospital Indemnity Insurance considered medical plans?

No. The benefits offer supplemental coverage and are not intended to replace your medical plan benefits. These voluntary benefits can help you cover your share of out-of-pocket costs under your medical plan should a covered accident, illness or hospital stay occur.

Do I have to be enrolled in an SAIC medical plan to have Accident Insurance, Critical Illness Insurance or Hospital Indemnity Insurance?

No. These plans are not linked to your SAIC medical plan enrollment so you do not need to be enrolled in an SAIC medical plan in order to enroll in the accident, critical illness or hospital indemnity insurance. Expats are not eligible.

Prescription Drugs (excluding Kaiser, Cigna International and Voluntary TRICARE Supplement)

Will I have to buy my prescriptions from a CVS Caremark retail pharmacy?

The CVS Caremark retail pharmacy network includes more than 68,000 pharmacies nationwide, including most chain pharmacies (e.g., Walgreens, Target, Walmart, Kroger, Rite-Aid, etc.) and many independent pharmacies. As an alternative to mail order, CVS Caremark retail pharmacies can provide mail-order discounted prices for 90-day prescriptions.

Effective January 1, 2020, CVS Caremark will cover refills of maintenance prescription medications for a 90-day supply at a CVS retail pharmacy or the CVS mail-order pharmacy. You will pay 100 percent of the cost if you choose to continue with a 30-day supply of your maintenance medications after the third fill.

How do the deductible and out-of-pocket maximum work for prescription drugs under the PPO Plan and the HSA-eligible plans?

PPO Plan: There is no deductible for prescriptions in the PPO. You will pay a copayment based on whether your prescription is for a generic, formulary brand or a non-formulary brand drug, and it counts toward your combined medical and prescription annual out-of-pocket maximum.

HSA-eligible Plans: A combined medical and prescription deductible applies. You will pay 100 percent of your non-preventive medical and prescription costs until you meet the annual deductible for the coverage level of your HSA-eligible plans. Once you meet the deductible, you will pay a coinsurance based on whether your prescription is for a generic, formulary brand or a non-formulary brand drug.

For both the PPO Plan and all HSA-eligible plans, the individual out-of-pocket maximum is embedded into the family out-of-pocket maximum. This means that once a covered member meets the individual out-of-pocket maximum, any eligible expenses incurred by that member throughout the remainder of the plan year will be covered by the plan at 100 percent, regardless of whether the entire family out-of-pocket limit has been met.

What is CVS Caremark?

CVS Caremark helps manage the prescription drug benefit for the PPO Plan and all HSA-eligible plans.

As a CVS Caremark member, you have access to more than 68,000 pharmacies nationwide including most major drugstores (e.g., Walgreens, Target, Walmart, Kroger, Rite-Aid, etc.) and many independent pharmacies. In addition, you are able to obtain 90-day supplies of maintenance medications (such as those you take to control high blood pressure and/or cholesterol) at either the CVS Caremark mail-order pharmacy or at a CVS retail pharmacy.

How can I locate a pharmacy within the CVS Caremark network?

You can log in to **www.caremark.com** from the **WellBeing365 portal** for information on participating pharmacies. You will need to register for the first time on the site and create a username and password.

How can CVS Caremark help me save money?

Your prescription cost depends on whether you use a generic or Tier-1 drug, preferred brand or Tier-2 drug, or a non-preferred brand or Tier-3 drug. Preferred medications have been selected by the Pharmacy and Therapeutics Committee, an independent committee of practicing physicians and pharmacists, and CVS Caremark. The committee reviews and evaluates medications to ensure they are safe and effective, and that they offer value to the plan and the consumer.

To see if you could save money on prescriptions, visit **www.caremark.com** from the **WellBeing365 portal**. You will need to register on the site for the first time and create a username and password. You can see if you have lower-cost alternatives available for the medications you take regularly. CVS Caremark tools allow you to enter or select a drug name and get information such as brand name and generic alternatives, estimated cost and whether or not the drug is covered under the plan. Simply look up the name of a medication to find lower-cost alternatives and potential savings. Then, print out the list of alternative drugs and ask your doctor if a lower-cost generic or preferred brand-name is okay for you to take and save money.

How will my doctor know which of my medications is on the preferred list?

The PPO plan and all HSA-eligible plans use the Performance Drug List (PDL) by CVS Caremark. The PDL provides a list of common medications typically covered by your plan, including generic and brand-name drugs. Discuss the drugs on the PDL with your doctor before your prescription is written, and ask your doctor if a generic or preferred drug is appropriate for you. You can find the PDL on the **WellBeing365 portal**, **https://wellbeing365.saic.com** or at **www.caremark.com**.

What is the CVS Caremark mail-order pharmacy?

The CVS Caremark mail-order pharmacy is part of the CVS Caremark pharmacy network and provides the convenience of home delivery. You'll typically save when you purchase a 90-day supply of your maintenance medications (such as those you take to control high blood pressure and/or cholesterol) at the CVS Caremark mail-order pharmacy. It is good practice to submit refill requests early, when you have a two-week supply on hand, to help avoid any issues should there be an unexpected delay in refilling the prescription by mail.

You may also take your 90-day supply prescription to a CVS Caremark retail pharmacy to receive your maintenance medications at the same cost as mail-order.

Is there any kind of coordination between the CVS Caremark drug plan and other coverage, such as Voluntary TRICARE Standard?

No. The CVS Caremark drug plan is not a stand-alone plan, nor will it function similarly to a Medicare Part D plan. Participation in the CVS Caremark drug plan requires concurrent participation in the PPO Plan or any of the HSA-eligible plans, in which case the SAIC plans would be primary payers for all services, both medical and prescription.

Where can I find a list of preventive medication?

You can find a list of preventive medications at **www.caremark.com** under the Covered Drug List section.

How do I estimate the cost of a drug and look for lower-cost options?

CVS Caremark has a Check Drug Cost tool that allows you to enter or select a drug name and search for generic or brand drug alternatives, estimated cost and what lower-cost drugs may be available in the formulary. Access this tool at **www.caremark.com**.

I'm taking a preventive, maintenance medication that's not included on the preventive medication list. Why can't it be included?

The Company and CVS Caremark are faced with some limitations with respect to which medications can be included on the preventive drug list. The IRS regulates the types of drugs that may be classified as preventive.

What is a specialty medication?

Specialty medications often treat complex and chronic conditions. They tend to be more expensive and can require special storage (refrigeration) or special administration (an injection). Most specialty medications do require additional support.

Can we influence what specialty medications are provided?

CVS Caremark determines which medications are considered specialty drugs. For coverage under the PPO and HSA-eligible plans, specialty medications must be filled at the CVS Caremark specialty pharmacy.

How do we find out which drugs are specialty drugs? How can we obtain the formulary?

To find out which drugs are categorized as specialty or to find out which drugs are included in the formulary (preferred), you can visit **www.cvsspecialty.com**.

If I'm in the PPO Plan or any of the HSA-eligible plans, is it to my benefit to use mail order for prescriptions or continue to go to a warehouse store such as Costco or Sam's Club?

Taking advantage of a mail-order drug program is convenient and in many cases can save you money. Occasionally, you will find a generic or other program that costs less than the PPO plan's copayment or the coinsurance amount for any of the HSA-eligible plans.

Will the CVS Caremark plan allow me to go to a retail pharmacy and purchase three months' worth of medicines for the cost of a mail-order prescription refill in the PPO plan or any of the HSA-eligible plans?

No. A 90-day supply of your medication can be filled at either the CVS Caremark mail-order pharmacy or a CVS retail pharmacy.

What happens if I purchase a brand-name medication when a generic equivalent is available?

You always pay the lowest price (the pharmacy usual and customary price) at the negotiated rate or your cost share. If the brand is Tier-1, you will pay your Tier-1 cost share. For all other brands with generic equivalents available, you will pay your cost share plus the difference in cost between the brand and generic, if any. If you choose to pay the difference in cost between the brand and generic drug, this difference will not apply toward your annual deductible or out-of-pocket maximum. In addition, you will continue paying the full amount of the difference even after you have met your annual out-of-pocket maximum.

What if the generic equivalent does not work for my condition?

If a generic equivalent is available but you receive the brand-name medication, you will pay your cost share plus the difference between the brand-name medication and the generic medication (unless the brand-name drug is on Tier-1 of the formulary). Generic drug equivalents contain the same active ingredients and are subject to the Federal Drug Administration (FDA) standards for quality, strength, and purity like their brand-name counterparts. If a generic equivalent is not available, you may wish to discuss generic alternatives with your doctor to determine if an alternative is appropriate for your condition.

Dental

Who is my provider for dental coverage?

Two PPO dental coverage options will be offered through Aetna or Cigna, depending on your location. The PPO options will cover the same services both in- and out-of-network, with a cost difference depending on whether you use an in-network or out-of-network service provider. Covered services between the Standard and Core dental plans vary. For example, the Core plan does not provide orthodontia coverage. Make sure the dental services you need are covered under the plan you select.

Where can I get more information about coverage for invisible braces?

After January 1, consult your dental plan provider directly.

How do I estimate the cost of a dental procedure?

Aetna has an Estimate Cost of Care tool to help review average cost information for in-network and out-of-network dental procedures in your area. Access this tool at **www.aetna.com**. Similarly, Cigna provides **brighter.com** tools, available on the **mycigna.com** website for provider searches and average cost information.

Vision

Are lenses and frames covered every 12 months?

Yes. Lenses and frames are covered every 12 months under both vision plan options — Standard and Core. This means that employees can receive a complete new pair of glasses — lenses and frames — every year.

How many vision plans are offered?

There are two vision plans offered — Standard and Core. Both are offered through VSP Vision.

Does the vision plan include both contacts and frames?

Both plans will cover either contacts or frames/lenses — not both.

Do I need to obtain a new prescription in order to get new frames?

You are able to get an exam, lenses and frames every year regardless of whether you've had a prescription change.

What is the difference between the Core and Standard plans offered through VSP Vision?

In addition to offering the same benefits as the Core Plan, the Standard Plan includes the "Easy Option", which allows you to choose one of the following:

- A $250 frame allowance (up from plan allowance of $180), or
- Anti-reflective lenses, or
- Progressive lenses, or
- Photo-chromatic lenses, or
- A $250 elective contact lens allowance in lieu of glasses (up from plan allowance of $180).

Commuter Benefit Program

What is the commuter benefit program?

The commuter benefit program allows you to set aside pre-tax money through the convenience of automatic payroll deductions to pay for eligible parking and transit expenses.

How much can I set aside each month for commuter expenses?

You can set aside:

- Transit expenses: up to $270 pre-tax per month to cover the cost of buses, trains, subways, etc.
- Parking expenses: up to $270 pre-tax per month to cover the cost of parking near your place of work or near your place of commuting to work.

You decide how much to contribute to a transit or parking expense account up to the IRS limits. You can choose to contribute to both a transit and parking expense account.

How do I enroll in the commuter benefit?

You can enroll in this benefit online at **www.wageworks.com**.

Can I enroll in this benefit only during Annual Enrollment?

No. This is a month-to-month benefit. You can enroll or discontinue participation at any time. However, all transit and parking orders must be received by the sixth day of the prior month in order to be processed.

Example: To enroll for April 2020, you must complete your order no later than March 6, 2020. Likewise, if you want to discontinue participation in the benefit for April 2020, you will need to cancel this benefit no later than March 6, 2020.

Where can I find more information about the commuter benefit program?

For more information, visit **www.wageworks.com/employees/commuter-benefit-accounts/**.

Short-Term Disability (STD) and Long-Term Disability (LTD)

What is STD?

The STD program provides financial protection for you and your family if you are unable to work because of a medical condition. Examples include a planned surgery, accident or illness and pregnancy. STD coverage is 100 percent paid by SAIC and automatically provided to you. Forward-deployed employees in fringe package 17 must elect STD as a voluntary benefit. STD pays a percentage of your base salary for up to 180 days (26 weeks) following the first week of disability. The plan provides income replacement at 66 2/3 percent of your base weekly earnings.

Does STD cover pregnancy?

Time taken off for pregnancy is covered under STD in the same way as any other covered illness or disability.

Why is it not an option to use STD if you need to be out with a sick child?

STD is meant to provide an income stream to employees who are out due to their own temporary disability. If an employee needs to tend to a seriously sick child, comprehensive leave, Family Medical Leave or Paid Family Leave (PFL) may be available to assist employees in this situation. Note, PFL is only offered in locations where it is state-mandated.

Voluntary Long-Term Disability (LTD)

What is LTD?

After 180 days of disability, you may be eligible to receive benefits through the Voluntary LTD plan. LTD benefits are designed to provide you with income if you are absent from work for six consecutive months or longer due to an eligible disability. LTD insurance provides a benefit of 60 percent of your base monthly salary up to $15,000 per month.

LTD coverage is an optional benefit when electing your benefits coverage. A pre-existing condition limitation will be in place for your first 12 months of coverage. In general, if you were diagnosed or received care for a disabling condition within the three consecutive months just prior to the effective date of your election, you will be covered for a disability due to that condition only if the date of disability is more than 12 months after your coverage effective date.

If you are currently enrolled in voluntary LTD, your election will automatically carry over into 2020.

Discount Program

What is BenefitHub?

BenefitHub provides discounts, rewards and perks on thousands of brands in a variety of categories such as travel, electronics, auto, etc.

Who can participate in BenefitHub, SAIC's discount program?

This benefit is open to all employees.

What types of discounts are offered through SAIC's discount program?

The discount program offers a variety of local and national discounts for various products and services. Discounts include automobile services, travel, entertainment, restaurants, clothing and appliances.

How do I access SAIC's discount program, BenefitHub?

You can access BenefitHub on the **Employee Discounts** page on ISSAIC or through the **WellBeing365 portal** at **https://wellbeing365.saic.com > Voluntary Benefits > Employee Discounts**.

Voluntary Benefits

What voluntary benefits are offered during 2020?

In addition to the supplemental medical benefits (Critical Illness Insurance, Accident Insurance and Hospital Indemnity Insurance), SAIC also offers Legal Services, ID Protection, Group Long-Term Care Insurance and Pet Insurance. You are responsible for the entire after-tax premium cost when you elect any voluntary benefit.

If I am currently enrolled in a voluntary benefit do I need to make a new election to continue my coverage in 2020?

Legacy Engility employees will need to elect voluntary benefits for 2020 with the exception of pet insurance. Legacy SAIC employees' voluntary benefits elections will carry over in 2020.

What is Legal Services Coverage?

Legal insurance makes it affordable to get the legal help you need: Network attorney fees are 100 percent paid-in-full for most covered matters.

What is ID Protection?

ID Protection protects and restores your identity and finances by continuously monitoring and investigating fraudulent activity, tracking web presence of compromised information and restoring your good name and standing.

What is Group Long-Term Care Insurance?

Group Long-Term Care Insurance provides coverage for extended skilled and custodial care in nursing homes, assisted living centers, home health care or hospice care.

What is Pet Insurance?

Pet Insurance provides coverage for out-of-pocket expenses associated with veterinary costs such as accidents and illnesses.

How do I enroll in a voluntary benefit plan?

Additional information for the voluntary plans can be found on the **WellBeing365 portal** at **https://wellbeing365.saic.com**.

This document does not determine rights under these plans. It is intended only to summarize the important provisions. SAIC benefits vary by fringe benefit package. Nothing in this brochure should be considered as altering or affecting the provisions of the plans themselves. The described benefit programs are subject to SAIC's eligibility guidelines. As with all of its benefits, SAIC reserves the right to amend or discontinue the benefits described in this document in the future, as well as change how eligible employees and the Company share the cost at any time. Certain coverage may not be duplicated for family members employed at SAIC. Certain coverage may be prorated for part-time employees.