REVATURE

2026 Employee Benefits Guide:

Associates and Software Engineers

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Your Employee Benefits

Revature strives to provide and takes pride in being able to offer comprehensive, essential and affordable benefits for our employees and their families. Our benefits package includes:

- Medical provided by Cigna
- Critical Illness, Accident, and Hospital provided by Cigna
- Dental provided by Guardian
- Vision provided by EyeMed
- Employer-Paid Life and AD&D provided by Guardian
- Voluntary Term Life, AD&D, and Long-Term Disability provided by Guardian
- Dependent Care, Commuter Transit & Parking provided by iSolved

This booklet contains an overview of the valuable benefits package available to you at Revature. While every effort has been made to ensure that this booklet accurately reflects the provisions of the plans, only the official plan documents govern the operation of the plans and payment of benefits.

IMPORTANT!

A cafeteria plan may allow a participant to change his or her elections for qualified benefits upon the occurrence of any of the following IRS recognized events:

As a result of Revature offering pretax deductions, changes to your health benefit elections are only permitted during the Open Enrollment period. It is very important that you understand your options since you cannot change coverage options unless you experience a Qualifying Event. If you experience a Qualifying Event during the plan year, you must notify Human Resources within 30 days of the event if you wish to make a change to your benefit elections. If the change is not submitted within 30 days of the event, you will not be able to make changes to your benefit elections until the next Open Enrollment Period.

- Court order
- COBRA qualifying event
- FMLA leave
- Eligibility for premium assistance through Medicare, CHIP, or other governmental program
- Exchange enrollment
- Reduction in hours of service to under 30
- Change in Legal Marital Status
  - Divorce/Annulment
  - Death of a Spouse
  - Marriage
  - Legal Separation
- Change in number of dependents
  - Death
  - Birth
- Gain or Loss of Eligibility for other group coverage
- Change in employment status of employee or spouse
- Change in place of residence (if moving in or out-of-network area)
- Entitlement to Medicare or Medicaid
- Change in coverage
  - Significant cost increases
  - Significant curtailment of coverage
  - Addition of significant improvement of benefit package option
  - Change in coverage under other employer
  - Loss of health coverage sponsored by governmental or educational assistance

General Plan Information

Eligibility

The below individuals are eligible to participate in Revature's medical plan and must provide proof of dependency to cover any dependents. If documentation is not provided, dependents will not be covered. **New hires are eligible first of the month on or after 60 days.**

ELIGIBLE DEPENDENT	DEFINITION OF ELIGIBLE EMPLOYEE AND DEPENDENTS	DOCUMENTATION REQUIRED
Employee	Any individual classified as a regular Full-time employee working at least 30 hours per week	Must meet employment eligibility requirements
Spouse*	Legally married to the participant/employee. Shall include a same-sex spouse who is legally married under applicable law	Marriage Certificate
Children	Participant's eligible children who have not attained age 26. Includes adopted children, children legally placed in your care, children of your legal spouse	Birth Certificate, Adoption Papers, Guardianship Papers

**A domestic partner shall not be considered a spouse.*

Qualifying Life Events

Certain events that affect an employee's change in eligibility may allow an employee/participant to change, add, or terminate coverage during the plan year. This is referred to as a special enrollment period or mid-year change. Events that may qualify for a special enrollment/mid-year change are as follows and require proof:

QUALIFYING LIFE EVENT (QLE)	DOCUMENTATION REQUIRED	MAX ALLOWABLE TIME TO REPORT CHANGE
Birth/Adoption	Birth Certificate, Adoption or Guardianship Papers	30 days from date of event (i.e., birth, final adoption or guardianship approval/signed by the court)
Marriage/Divorce/ Legal Separation	Marriage Certificate, Divorce Decree, Separation Papers	30 days from date of event (i.e., marriage date, final divorce decree/legal separation approval/signed by the court)
Spouse/Dependent Gains or Loses Coverage	Letter on company or carrier letterhead from new/former employer or insurance carrier showing effective date of coverage or loss, who is/was covered, and under what plans.	30 days from new coverage effective date or coverage loss date

Documentation not provided within the 30-day window and appropriate proof of dependency will have to wait until Revature's next Open Enrollment period. If approved, coverage would be effective at the start of the new plan year effective January 1st, unless otherwise determined by the benefits team after review.

How to Enroll

Revature employees will use the Workday Portal to enroll/make changes to your benefits elections – **Workday Portal**. For additional instructions on navigating the benefits enrollment functionality in Workday, please access the instructions on Sharepoint **2026 U.S. Benefits**.

ID Cards

Cigna Medical (Group #3344935) – Effective 1/1/2024, Cigna began to provide all ID cards electronically via the Cigna mobile app or **www.mycigna.com**. Please download the app to your cellphone or log in via your computer and create an account using your SSN, to retrieve your ID card. If you prefer a physical copy, you may contact Cigna at (800) 244-6224 and request that a physical ID card be mailed to you.

Guardian Dental (Group #00434782) – New hires or new enrollees to the Revature plan, will receive a physical ID card from Guardian. Continuing enrollees will not receive a physical ID card, but can access their ID card via the Guardian app or **guardianlife.com/dental-insurance/group**. If you prefer a printed card, please access via the Guardian portal as listed and print out.

EyeMed Vision (Group #1021301) – New hires or new enrollees to the Revature plan, will receive a physical ID card from EyeMed. Continuing enrollees will not receive a physical ID card, but can access a renewal ID card via the EyeMed app or **www.eyemed.com**. If you prefer a printed card, please access via the EyeMed portal as listed and print out.

Should you require additional assistance, please contact **HR@revature.com**.

When Your Coverage Ends

Your medical, dental, vision, and Cigna Supplemental coverages will end on the last day of the month of your date of termination. All other coverages will end on your termination date. At that time, you will be eligible for COBRA benefits for any applicable benefits.

Key Issues to Factor Into Your Planning

If you have medical coverage elsewhere (through your spouse's employer-sponsored plan, for example), consider whether it would be more practical for you to cover your dependents (or yourself) under that plan (based on your family's health needs) instead of Revature's medical plan. Remember that benefits payable under Revature's plans are coordinated with benefits payable under your spouse's employer-sponsored plan. Generally, the benefit, if any, of having dual coverage varies widely based on the plans available and should be carefully evaluated for exclusions or limitations prior to enrolling into one or more plans.

Always review factors like copays, coinsurance, deductibles, etc. prior to selecting a benefits package. Don't assume your benefit options are the same as prior years. Make sure to select the plan that best addresses your current health and welfare needs.

- Consider how you have utilized your current plan during the previous year and what your expected medical needs are for the coming year.
- Review all available options to you, including coverage for spouse, children, etc.
- Most benefit plans are "a la carte." You may take all, none, or several of the benefits that fit your needs.

A Special Note About Timing

Due to insurance carrier timelines, it is not uncommon to receive your ID card after the official start date of your coverage. Planning ahead when you may not yet have your ID card, will help ensure that you have a smooth transition. Here are a few ways to adequately plan ahead:

- If you take any medicine, get a refill before the start date of your new coverage.
- If you have any doctor's appointments occurring within the first few days of your new plan, ask the doctor if they will accommodate you or if they can reschedule the appointment.

Highlights of the Affordable Care Act (ACA)

- Preventive Services are covered at 100%.
- Dependents are eligible for coverage up to age 26, regardless of dependency status.
- No pre-existing medical conditions apply to any new or renewing plans with an effective date of 1/1/2014 or later.

Key Terms

DEDUCTIBLE

The amount that must be paid per benefit period before insurance begins to pay its portion of claims. The deductible amount may vary based on whether it is individual or family coverage.

DEDUCTIBLE

Jane pays 100%	Her plan pays 0%

COINSURANCE/COPAYMENT

Jane pays 20%	Her plan pays 80%

COINSURANCE

The percentage or amount the member is required to pay in conjunction with their insurance plan after the deductible has been met.

COPAYMENT

A fixed payment that an insurer may require the patient to pay for certain covered expenses (such as office visits or prescription drugs). Copays go toward your out-of-pocket maximum but do not go toward your deductible.

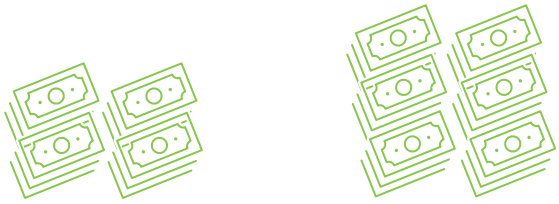
OUT-OF-POCKET MAXIMUM

The maximum amount a member will pay out-of-pocket during the benefit period. This amount includes deductibles, coinsurance and copayments. Once the out-of-pocket maximum is met, the insurer will pay 100% of the allowed amount for covered services, for the remainder of the benefit period.

OUT-OF-POCKET MAXIMUM

Jane pays 0%	Her plan pays 100%

OUT-OF-NETWORK / BALANCE BILLING



Jane pays 40%	Her plan pays 60%

OUT-OF-NETWORK

An out-of-network provider does not contract with the health insurance plan. In many cases, the insurance company will not pay or will pay substantially less for services you receive from an out-of-network provider. Out-of-network claims may be subject to balance billing. In these instances, the provider will bill the patient for the difference between what the patient's insurance pays and what the provider bills.

Medical Benefits

Cigna Plans

BENEFITS RESET ON A CONTRACT YEAR FEBRUARY 1ST TO JANUARY 31ST		
IN-NETWORK	**NATIONAL OAP 750**	**NATIONAL OAP HDHP W/ HSA**
Doctor Copay (PCP/Specialist)	$25/$50	Ded + Coins
Deductible (Individual/Family)	$1,000/$2,000	$2,000/$4,000
Coinsurance (Insurance/Member)	80%/20%	80%/20%
Inpatient Hospitalization	Ded + Coins	Ded + Coins
Outpatient Surgery (PCP/Specialist)	$25/$50	Ded + Coins
Physical Therapy	Ded + Coins / 30 visits max	Ded + Coins / 30 visits max
Mental Health Services (Inpatient/Outpatient)	Ded + Coins	Ded + Coins
Mental Health Office Visits	$25 Copay	Ded + Coins
Lab / X-Ray / Advanced Diagnostics	Ded + Coins	Ded + Coins
Urgent Care	$25 Copay	Ded + Coins
Emergency Room	$250 Copay	Ded + Coins
Out-of-Pocket Maximum (Ind/Fam)	$3,500/$7,500	$4,000/$8,000
OUT-OF-NETWORK		
Deductible (Individual/Family)	$2,000/$4,000	$4,000/$8,000
Coinsurance (Insurance/Member)	60%/40%	60%/40%
Out-of-Pocket Maximum (Ind/Fam)	$7,000/$15,000	$8,000/$16,000
COVERED PRESCRIPTIONS		
Deductible	$0	Combined w/med
Retail (Tier 1/Tier 2/Tier 3)	$15/$40/$65	Ded + Coins
Mail-Order (Tier 1/Tier 2/Tier 3)	$30/$80/$130	Ded + Coins
Tier 4 (Specialty)	50% up to $200	Ded + Coins
Monthly Deductions		
Employee Only	$190.00	$119.00
Employee + Spouse	$609.00	$478.00
Employee + Child(ren)	$556.00	$433.00
Employee + Family	$790.00	$629.00

Medical Benefits (cont.)

Where You Received Care Matters

When your injury/sickness is non-life threatening, going to an Urgent Care rather than the Emergency Room can provide savings.

Where you receive services impacts your out-of-pocket costs. For example, received lab work at a freestanding lab facility will cost less than same lab work at a hospital facility. This difference in cost is based on place of service and applies to PCP/Specialist office visits, diagnostic services (labs, x-rays, and imaging) and other outpatient services.

To Find Participating Providers

http://www.cigna.com/web/public/hcpdirectory

To locate participating In-Network providers, select the first choice "Open Access Plus".

USE AN IN-NETWORK PROVIDER WHENEVER POSSIBLE
• You will receive a higher level of benefits and discounted fees. • You will not have to worry about reasonable and customary limitations. • You will get more covered services.

Please refer to your Summary Plan Description for rules and information on Dependent Age limits as it pertains to each plan offered. Health care reform and many other variables may play a role in this area, so the dependent ages may vary from one plan to the next. This benefit summary is meant to be representative of your group benefits offered, but the Summary Plan Description from each plan is the ruling contract with the health carrier. Please refer to that for further clarification.

Prescription Benefits

What can I expect to pay?

After any applicable deductible, the amount you pay depends on the drug your doctor prescribes. Refer to your Medical Benefits page for details.

What You Pay Falls Into One of Four Tiers:

- Preferred Generic/Tier 1 – This is the lowest cost tier. Your plan may include an additional benefit where some Tier 1 drugs are further discounted and considered Value Drugs/Tier 1a and include generics and some over-the-counter brand products.
- Preferred Brand/Tier 2 – These are commonly brand-name medications that don't have a generic equivalent.
- Non-Preferred Brand and Generic/Tier 3 – These are the high-priced brand name and generic medications.
- Specialty/Tier 4 – These specialty drugs may be injected, infused or taken by mouth. When enrolled in a plan with 4 drug tiers, you pay the highest cost at this level.

To Find Your Exact Costs:

Check your Plan Design and Benefits summary.

Cigna requires you to register online to get your specific prescription plan information.

Why is the formulary subject to change?

A carrier may add or remove drugs for certain reasons. They might also move a drug from one coverage tier to another. Here are some reasons why:

- As brand-name drugs lose their patents and generic versions become available, the brand-name may be covered at a higher out-of-pocket cost while the generic may be covered at a lower out-of-pocket cost.
- The Food and Drug Administration (FDA) approves many new drugs throughout the year.
- Drugs can be withdrawn from the market or may become available without a prescription.

As new drugs are developed, it takes time for insurance carriers to evaluate their effectiveness. New drugs can be very costly. To keep costs down for members, while still making sure you get the safest, most effective, and reasonably-priced drug available, some carriers have instituted a step therapy program.

Prescription Benefits (cont.)

What is step therapy?

Step therapy is a type of prior authorization for medications. It requires trying other medications before "stepping up" to drugs that cost more. The carrier wants to know that less expensive options don't work before your plan will cover the more expensive drug. Here's an example of step therapy:

- You try an over-the-counter medication for your allergy, but it doesn't control your symptoms.
- Your doctor prescribes a prescription drug that still doesn't give you relief.
- A third medication that's more expensive works well, but requires step therapy.

In this case, your prescription may be covered. If you haven't tried step therapy, the drug may cost you more, or may not be covered at all.

What do I need to do if my prescription requires step therapy?

If your drug needs approval, either you or your pharmacist will need to let your doctor know. They might switch your therapy to another drug that doesn't require approval from the health plan or your doctor will contact our Pharmacy Help Desk to start the approval process and tell us the information we need.

GET MORE FOR LESS!

Prescription Drug Savings: Brand vs. Generic

They are the same: Generic drugs are FDA approved copies of brand-name drugs that have exactly the same dosage, intended use, effects, route of administration, risks, safety, and strength as the original drug. Although they may look or taste different, generic drugs are cheaper because manufacturers have not had the expense of developing and marketing the drug.

They save you money: Generic drugs are often 80 percent less expensive than brand name medication. The next time you need a prescription, ask if a generic equivalent is available. Or, if your doctor does not specifically tell you to only take the brand-name drug, ask your pharmacist to fill your prescription with the generic version, if one is available.

You may be subject to a Brand Penalty for choosing a brand name prescription when there is a generic available. In this situation you would pay your copay along with the difference between the brand name and generic drug.

Health Savings Account (HSA)

What is an HSA?

A Health Savings Account (HSA) is a tax-advantaged savings account that can be used for your health care expenses. Your contribution comes out of each paycheck and is deposited into the account for future use.

If you have a qualified high deductible health plan, an HSA can help provide some security for your health care costs and limit out-of-pocket expenses.

Is an HSA right for you?

HSAs can be very cost effective, but they are not for everyone.

If you have a high deductible health insurance plan and are able to come up with a reasonable estimate of your health care expenses each year, you could potentially save a great deal of money with an HSA.

If you have a chronic condition but you know your annual expenses and are able to budget enough money to cover your health care costs, an HSA could also be beneficial.

If you are unable to cover unexpected expenses up front, you might want to consider a more traditional plan. Otherwise, you can change your future contributions and pay yourself back with tax-free money as long as your account was open and active at the time of the expense.

Advantages of an HSA

An HSA can help you save money and conveniently pay for health care costs.

An HSA provides triple tax benefits. Since the deposits are coming straight out of each paycheck, the money you contribute to an HSA is pretax, and the interest that accumulates in the account is tax-free. In addition, money withdrawn from an HSA is not taxed, provided that you use it for qualified medical expenses.

Consulting an accountant when filing your taxes for the first time with an HSA is recommended to ensure you receive all the tax advantages.

You can budget for anticipated expenses each year such as maintenance medications or regularly scheduled non-preventive care. If you do not utilize all your funds, your balance will continue to grow each year and will be available for you to use for future health care expenses. Any unspent dollars will roll over each year.

Investments

Employees or other individuals with HSAs may invest the funds in their accounts after meeting a required minimum balance. HSA funds may be invested in the same types of investments approved for IRAs (e.g., bank accounts, annuities, certificates of deposit, stocks, mutual funds, or bonds). The account holder controls all decisions over how the money is invested. Owners of HSAs can also choose not to invest their funds.

Health Savings Account (HSA) (cont.)

What can my HSA pay for?

HSA funds can be used to pay for any "qualified medical expense" even if that expense is not normally covered by a medical plan. For example, most health insurance does not cover chiropractic or acupuncture, but HSAs can. For a full list of qualified expenses visit: **www.irs.gov/publications/p502/index.html**

More Information on HSAs

For more information on HSAs including requirements around HSA contributions and distributions, please see IRS publication 969 **www.irs.gov/pub/irs-pdf/p969.pdf**.

CONTRIBUTION LIMIT (EMPLOYER + EMPLOYEE)	2026
Single	$4,400
Family	$8,750
Catch-Up (55+) (Single or Family)	$1,000

IMPORTANT NOTES!

To be eligible for an HSA, you must meet the following requirements:

- Must be covered under a high deductible health plan (HDHP) on the first day of the month.
- Must have no other health coverage including, but not limited to Medicare, Tricare, or any other first-dollar coverage.
- Cannot be claimed as a dependent on someone else's tax return.

Important Notes: Under the last-month rule, you are considered to be an eligible individual for the entire year if you are an eligible individual on the first day of the last month of your tax year (December 1 for most taxpayers).

If you meet these requirements, you are an eligible individual even if your spouse has non-HDHP family coverage, provided your spouse's coverage doesn't cover you.

Can I use my HSA to pay for medical expenses incurred before I set up my account? No. You cannot reimburse qualified medical expenses incurred before your account is established.

It is your responsibility to activate your HSA account and respond to any Patriot Act related inquiries once enrolled in your HDHP plan. Failure to do so may result in non-reimbursable expenses and/or account closure.

Health Savings Account (HSA) (cont.)

How much can you Save?

The example below illustrates how you can save by participating in a Health Savings Account (HSA).

WITHOUT HSA	
Gross Annual Pay	$50,000
Estimated Tax Rate (24%)	($12,000)
Your Take-Home Pay	$38,000

WITH HSA	
Gross Annual Pay	$50,000
HSA Contribution	($3,500)
Your Adjusted Gross Annual Pay	$46,500
Estimated Tax Rate (24%)	($11,160)
Your Take-Home Pay	$38,840

In this example, you would have an estimated $840 in tax savings for the year and have a Net of $3,500 saved in HSA funds that can be used for any medical expenses such as copays, dental work, eye surgery, prescription medication, etc. Additionally, all of the money in an HSA is owned by you even if you leave your job, lose your qualifying coverage or retire. The money in an HSA never expires.

Please note: this is not tax advice. If you are seeking tax advice, please contact your local tax advisor.

Cigna Supplemental Health Benefits

All eligible employees will have the opportunity to enroll in Cigna's Supplemental Health plans. An unexpected illness or injury can disrupt every facet of your life, including your physical, emotional and financial well-being. Regular expenses, big and small, can add up. These voluntary benefits are designed to help strengthen your overall benefits package and provide additional protection for you and your family through **fixed benefits paid directly to YOU**.

Key Features to Consider:

- **Flexible.** Use the money however you want. Pay for anything you need – medical deductibles, child care, groceries, etc.
- **Supplement your medical plan.** Benefits are paid in addition to other coverage you may have.
- **Cost effective.** Your premium is conveniently deducted from your paycheck at a low group rate.

 **ACCIDENTAL INJURY INSURANCE**	**Pays a fixed cash benefit directly to you[1] when you have a covered accident-related injury, like an ankle sprain or arm fracture.**	Accidental Injury Benefit Example **Situation:** Chloe broke her leg playing soccer.[2] Chloe's covered benefits: – Doctor's office visit – Broken leg – Diagnostic exam (X-ray) – Physical therapy sessions **Accidental Injury benefit** paid directly to Chloe: $1,200
 **CRITICAL ILLNESS INSURANCE**	**Pays a fixed, lump-sum cash benefit directly to you[1] when you are diagnosed with a covered health condition, such as a heart attack or stroke.**	Critical Illness Benefit Example **Situation:** Marco had a heart attack while raking leaves.[2] Marco's covered benefits: – Heart attack diagnosis **Critical Illness benefit** paid directly to Marco: $10,000
 **HOSPITAL CARE INSURANCE**	**Pays a fixed cash benefit directly to you[1] when you experience a covered hospital[3] stay, for events like an in-patient procedure or childbirth.**	Hospital Care Benefit Example **Situation:** Susan was hospitalized[2] following a car accident. Susan's covered benefits: – Hospital admission – Hospital ICU stay – Hospital stay **Hospital Care benefit** paid directly to Susan: $2,000

IF YOU ARE INTERESTED IN ENROLLING, PLEASE INDICATE YOUR ELECTIONS DURING YOUR ENROLLMENT WINDOW.

Please note the above descriptions are only a brief summary and examples are provided for illustrative purposes only. Refer to the Benefit Summaries for more details on your coverage, election options, and rates.

[1] Benefits may be paid directly to anyone you designate, such as a hospital, upon assignment.
[2] This is an example used for illustrative purposes only. Your plan's actual costs and benefit amounts may vary. Exclusions and limitations apply.
[3] The term "hospital" does NOT include a clinic, facility or unit of a hospital for: (1) Rehabilitation, convalescent, custodial, educational, hospice or skilled nursing care; (2) the aged, drug addiction or alcoholism; or (3) a facility primarily or solely providing psychiatric services to mentally ill patients.

Easy Ways to Submit a Claim

When a serious illness or injury occurs, Cigna Accidental Injury (AI), Critical Illness (CI) and Hospital Care (HC) insurance can help you bounce back to your best, body and mind. That's why it's important to submit your claims as soon as possible. There are five easy ways to file. Simply choose the option that's easiest for you.

Phone	Call **1.800.754.3207** to speak with one of our dedicated customer service representatives
Online	Visit **SuppHealthClaims.com**
Fax	Send documents to **1.866.304.3001**
Email	Send scanned documents to **SuppHealthClaims@Cigna.com**
Mail	Send documents to: **Cigna Supplemental Health Solutions** P. O. Box 188028 Chattanooga, TN 37421-9702

FOR QUESTIONS, OR TO CHECK ON THE STATUS OF YOUR CLAIM,

call **1.800.754.3207**, 7:00 am-7:00 pm (CST).

After You File

A designated claim manager will be assigned to your claim. If they have any questions or need additional information, they will contact you, the beneficiary, or provider to obtain the needed information.

- Once all requested information is submitted, Cigna will pay your claim quickly – in days, not weeks.
- Benefits are paid directly to you,** for a covered critical illness, accidental injury or hospitalization.***

When should I file my claim?

Claims should be reported as soon as possible. Standard policy provisions call for the notification of claims from within 31 days of the date of the loss and "proof of loss" within 90 days. Claims outside of these time frames will still be evaluated for their timeliness, but must be reported within one year from their required 90 days "proof of loss." Once we've received all the requested information, we can begin reviewing and processing the claim.

How am I notified of the decision?

If the claim is approved, you'll receive an explanation of benefits (EOB) or approval letter advising you of the decision. If the claim is denied, you'll receive an EOB or letter explaining why the claim was denied and instructions on how to appeal the denial.

What information will I need to file my claim?

Make sure you have this information handy:

- Completed claim and disclosure authorization forms, which can be found online at **Cigna.com/customer-forms**
- Personal information, such as your name, address, phone number, birth date, Social Security number and email address
- Employment information, such as employer's name, email address, date of hire and job title
- Doctor and hospital information – The name, address and phone number of each doctor or hospital you're using for this accident, injury or illness
- Itemized medical bills, if available

*The Simple File process is based on a one-time assessment of the initial claim documentation for the primary claim. Any subsequent events would not be identified and the customer will need to submit a claim for any supplemental health benefits.
** Benefits may be paid directly to the hospital upon assignment.
*** The term "Hospital" does not include a clinic, facility, or unit of a Hospital for: (1) rehabilitation, convalescent, custodial, educational, hospice, or skilled nursing care; (2) the aged, drug or alcohol addiction; or (3) a facility primarily or solely providing psychiatric services to mentally ill patients.

Dental Benefits

Guardian

BENEFITS RESET ON A CALENDAR YEAR JANUARY 1ST – DECEMBER 31ST		
IN-NETWORK	**GUARDIAN PPO**	**GUARDIAN PPO ALTERNATIVE**
Deductible (Waived for preventive)	$50	$25
Preventive (Class I)	100%	100%
Basic (Class II)	80%	90%
Major (Class III)	50%	60%
Orthodontia (Class IV)	50%	50%
Maximum Benefit (per member)	$1,000	$2,500
Orthodontia Lifetime Maximum Benefit (per member)	$1000 Child Only	$2500 Child Only
Waiting Period for Major Services	none	none
OUT-OF-NETWORK		**90th UCR**
Deductible	$100	$75
Preventive (Class I)	100%	100%
Basic (Class II)	50%	75%
Major (Class III)	25%	50%
Orthodontia (Class IV)	50%	50%
Deductible Waived for Preventive	No	No
Maximum Benefit (per member)	$1,000	$2,500
Orthodontia Lifetime Maximum Benefit (per member)	$1000 Child Only	$2500 Child Only
Waiting Period for Major Services	none	none
ADDITIONAL COVERAGE INFO		
Perio and Endo Services	Basic	Basic
Implants Covered	Yes	Yes
White Fillings Covered	Yes	Yes
Dependent Age/Student Age	26/26	26/26
Monthly Deductions		
Employee Only	$22.36	$35.45
Employee + Spouse	$44.51	$70.56
Employee + Child(ren)	$52.89	$102.91
Employee + Family	$75.05	$140.78

WHAT DOES DENTAL INSURANCE COVER?

Dental coverage focuses on preventive and diagnostic procedures in an effort to avoid more expensive services associated with dental disease and surgery. The type of service or procedure determines the amount of coverage for each visit. Each type of service fits into a class of services according to complexity and cost. Dental services are generally broken up into the following classes:

- Class I – diagnostic and preventive care (cleanings, exams, X-rays)
- Class II – basic care and procedures (fillings, root canals)
- Class III – major care and procedures (crowns, bridges, dentures)
- Class IV – orthodontia (braces)

Because dental coverage typically focuses on preventive care, Class I services are covered at the highest percentage. Class II services are then covered at a slightly lower percentage, followed by Class III services, which are covered at the lowest level. For example, if a plan follows a "100-80-50" structure, Class I services are covered at 100 percent, Class II at 80 percent and Class III at 50 percent.

Class IV services are frequently covered under a separate lifetime maximum (instead of the annual maximum) and often limit coverage to children under the age of 1.

To Find a Participating Provider:

https://www.guardiananytime.com/fpapp/FPWeb/dentalSearch.process

- Guardian PPO, select plan: **PPO**
  - Dental Network, Select – **DentalGuard Preferred**

Please refer to your Summary Plan Description for rules and information on Dependent Age limits as it pertains to each plan offered. Health care reform and many other variables may play a role in this area, so the dependent ages may vary from one plan to the next. This benefit summary is meant to be representative of your group benefits offered, but the Summary Plan Description from each plan is the ruling contract with the health carrier. Please refer to that for further clarification.

Vision Benefits

BENEFITS RESET ON A CONTRACT YEAR FEBRUARY 1ST TO JANUARY 31ST	
IN NETWORK	**EyeMed Vision**
Routine Eye Examination	$0 copay
Materials (Single/Bifocal/Trifocal Lenses)	$0 copay
Frames	$0 copay
Elective Contact Lenses	Up to $130
Standard Progressive Lenses	$55 copay
LASIK	Up to 15% off retail; 5% off promotionals
OUT-OF-NETWORK	
Routine Eye Examination	Up to $45
Frames	Up to $45
Single Vision Lenses	Up to $52
Bifocal Lenses	Up to $82
Trifocal Lenses	Up to $101
Elective Contact Lenses	Up to $97
SCHEDULE OF FREQUENCY	
Eye Examination	12 months
Lenses	12 months
Frame	12 months
Contacts	12 months
Contacts are in lieu of glasses	Yes
Monthly Deductions	
Single	$5.95
Employee + Spouse	$11.28
Employee + Child(ren)	$11.88
Family	$17.47

WHOM YOU SEE MAY DEPEND ON THE LEVEL OF CARE YOU NEED.

- An **optician** is a specialist in fitting eyeglasses and making lenses to correct vision problems.
- An **optometrist** is a primary health care doctor of the eye and visual system who provides comprehensive eye and vision care, which includes refraction and dispensing, detection of disease in the eye, and the rehabilitation of conditions of the visual system.
- An **optometrist** may perform an eye exam and write a prescription for corrective lenses, while an optician may fill that prescription.
- An **ophthalmologist** is a medical doctor who specializes in all aspects of eye care including diagnosis, management, and surgery of ocular diseases and disorders.
  It's common for ophthalmologists or optometrists to work side-by-side with opticians to serve a patient's overall eye care and eyewear needs. Let's use a real-life scenario: an optometrist performs your thorough eye exam and prescribes corrective lenses. You're then escorted to the eyeglass area where an optician helps you select your frames and lens options. If surgery is indicated or if the optometrist detects an eye concern that is outside of his or her scope of practice, you may be referred to an ophthalmologist for more advanced care. Now keep in mind, this is one typical scenario, but not necessarily indicative of all situations.

To Find Participating Providers:

https://www.eyemedvisioncare.com/locator/locator.emvc?execution=e1s1

Under "Choose Network", select Insight

Please refer to your Summary Plan Description for rules and information on Dependent Age limits as it pertains to each plan offered. Health care reform and many other variables may play a role in this area, so the dependent ages may vary from one plan to the next. This benefit summary is meant to be representative of your group benefits offered, but the Summary Plan Description from each plan is the ruling contract with the health carrier. Please refer to that for further clarification.

Income Replacement Benefits

As a part of Revature's benefits, we provide you with Life and Accidental Death & Dismemberment (AD&D) coverage. You also have the opportunity to enroll in supplemental Voluntary Term Life, AD&D and LTD coverage. These programs offer you and your family financial protection against some of the uncertainties life can bring.

Life and Accidental Death and Dismemberment

Revature provides a replacement for lost income in the event of your untimely death, thereby providing an inheritance for heirs and funds for final expenses.

Voluntary Term Life and AD&D

This would be in addition to the group paid insurance and should be based on your family's personal financial needs.

EVIDENCE OF INSURABILITY
If you elect to add coverage outside of your initial eligibility or elect amounts of coverage higher than the guarantee issue amount you will be required to complete an Evidence of Insurability form.

Long-Term Disability

LTD is employee-paid. If you become disabled, long-term disability insurance will pay out a set amount or a percentage of your regular income in monthly intervals. Long-term disability provides you income protection for extended periods of time due to disability, sickness or injury not related to your job.

LIFE AND AD&D	
Benefit Amount	$50,000
VOLUNTARY TERM LIFE	
Employee Benefit Amount	Increments of $10,000 not to exceed $500,000
Employee Guaranteed Issue	$250,000
Spouse Benefit Amount	Increments of $5,000 up to $250,000 not to exceed 100% of employee coverage
Spouse Guaranteed Issue	$30,000
Dependent Children Amount	$10,000 not to exceed 10% of employee coverage
Dependent Children Guaranteed Issue	$10,000
AD&D Benefits	Matches Life

* Please note that guaranteed issue amounts apply only at time of hire or a change in status from part-time to full-time. All request for an increase in coverage during Open Enrollment will require an EOI.

LONG-TERM DISABILITY	
Monthly Benefit	60%
Maximum Monthly Benefit	Up to $5,000
Elimination Period	90 days
Max Duration of Benefits	Up to Social Security Normal Retirement Age

PRIMEPAY

Dependent Care Benefits

The Dependent Care FSA

The Dependent Care FSA lets you use pretax dollars toward qualified dependent care. The annual maximum amount you may contribute is $5,000 (or $2,500 if married and filing separately) per calendar year. To be eligible to contribute to a dependent care account, generally both you and your spouse must work or look for work. One spouse is treated as working during any month he or she is a full-time student or is not physically or mentally able to care for himself or herself.

If you elect to contribute to the dependent care FSA, you may be reimbursed for:

- The cost of eligible child or adult dependent care either in or out of your house by an eligible caregiver
- Nursery schools and preschools (excluding kindergarten)

Dependent Care FSAs employ a "use-it-or-lose-it" model. If you do not use the funds that you contribute to your FSA within the plan year, you will have to forfeit those funds.

- Upon termination, you will have 90 days to submit claims for daycare expenses incurred during the plan year for reimbursement. Funds not claimed within the 90 days will be forfeited.

Eligible Expenses

For more information about eligible dependent care expenses, please refer to IRS Publication 15-B available at **https://www.irs.gov/forms-pubs/about-publication-15-b**.

What is a Dependent Care FSA?

- A Dependent Care FSA (DCFSA) is a pretax benefit account used to pay for eligible dependent care services, such as preschool, summer day camp, before or after school programs, and child or adult daycare. It is a smart, simple way to save money while taking care of your loved ones so you may continue to work.

FEATURES OF THE FSA PLAN	
Plan year	1/1/2026 to 12/31/2026
Dependent Care Max	$5,000
You must re-enroll annually – No Exceptions!	

Commuter Transit & Parking Benefits

A Transportation Reimbursement Account is an employer-sponsored plan governed by Section 132 of the Internal Revenue Code. This plan allows employees to pay for work-related transit vouchers, vanpooling, and qualified parking expenses with pretax dollars.

- Transit Passes / Commuter Highway Vehicle - $340 per month
- Qualified Parking - $340 per month

ELIGIBLE EXPENSES

For more information about eligible transportation expenses, please refer to IRS Publication 15-B available at **https://www.irs.gov/forms-pubs/about-publication-15-b**.

WHAT IS A COMMUTER TRANSIT BENEFIT?

- A Commuter Transit Benefit is a pretax benefit account used to pay for public transit – including train, subway, light rail, bus, and ferry – as part of your daily commute to work. It's a great way to put extra money in your pocket each month and make your commute more convenient and affordable. You may contribute to your account up to $340 per month on a pretax basis to pay for transit expenses, which means you end up paying less in taxes and taking home more of your paycheck.
- A vanpool can be organized by a company or by an individual. An eligible vanpool has seating for 6 or more adult passengers (excluding the driver). Fifty percent of a vanpool seating capacity is used for employee transport, and 80 percent of the mileage is to transport employees.

FEATURES OF THE FSA PLAN	
Plan year	1/1/2026 to 12/31/2026
Parking and Transit	$340 per month each
You must re-enroll annually – No Exceptions!	

WHAT IS A COMMUTER PARKING BENEFIT?

- A Commuter Parking Benefit is a pretax benefit account used to pay for parking as part of your daily commute to work, including parking at or near you place of work or at a location near where you take public transportation to get to work. It's a great way to put extra money in your pocket each month and make your commute more convenient and affordable.
- You may contribute to your account up to $340 per month on a pretax basis to pay for parking expenses, which means you end up paying less in taxes and taking home more of your paycheck. Plus, you can opt to have your parking provider paid directly taking one item off your to do list.

HOW DOES IT WORK?

https://infinconsumer.lh1ondemand.com/Login.aspx

- You will need to complete your enrollment via the Workday enrollment system
- Any election made by the 15th of the month will be effective on the 1st of the month following your election. Any election made after the 15th of the month will be effective on the 1st of the second month following your election.
- Once enrolled, you will receive an iSolved Card which can be used to pay for eligible Parking and Transit expenses. It works just like a debit card - swipe and go! The money will be available on the card the same day as the payroll cycle.
- iSolved has an online portal that is very comprehensive. You can check your balance, file claims, view pending or past claims, opt-in/out of electronic communications (email/mobile text), and more.
- If you terminate employment, there will be a period of time after your termination for which you may submit claims for expenses incurred prior to termination. Your debit card will be deactivated and all claims must be filed within 90 days to receive reimbursement. Any funds not claimed within 90 days will be forfeited.

Paid Time Off – Accrual Schedule

Associates/Software Engineers

If you are an active, full-time employee working at least 30 hours per week, you are eligible for coverage beginning the first of the month following 60 days of employment.

PAID TIME OFF — ACCRUAL SCHEDULE

The highest number of hours that can be held in your balance of hours at any time is 200 hours.

PERIOD	BI-WEEKLY ACCRUAL RATE
0 - 12 Months	2.31 Hours/Pay Period
13 - 24 Months	3.31 Hours/Pay Period
25 - 36 Months	3.62 Hours/Pay Period
37 - 48 Months	3.92 Hours/Pay Period
49 - 60 Months	4.23 Hours/Pay Period
61 Months+	4.31 Hours/Pay Period

401(k) Retirement Plan

- Eligible employees may elect to defer on the first day of the month following your date of hire.
- Participants may elect 1% to 90% of eligible compensation on a pre-tax or post-tax basis up to the annual IRS limit, including any catch-up provisions.
- To contribute, employees must make selection in Fidelity.
- Revature may provide a company match of 50% up to the first 6% contribution of eligible wages, after meeting 1 year of service.
- Information on how to complete account set-up with Fidelity's NetBenefits will be emailed to you within 7–10 days of your start date.

Fidelity (Policy #55437)
www.Fidelity.com
Customer Service: (800) 835-5097

Investment Advisor: CAPTRUST
www.captrustadvice.com
Contact: (800) 967-9948

PerkSpot Discount Program

Welcome to Your Revature Discount Program

SAVE ON THOUSANDS OF YOUR FAVORITE BRANDS.

verizon Budget SAMSUNG sam's club

CREATE YOUR ACCOUNT

Get started by creating your account at: **revature.perkspot.com**

SUBSCRIBE TO WEEKLY PERKS

Subscribe to weekly emails to make sure you never miss a deal!

CHOOSE YOUR PERKS

From travel to electronics, choose from over 25 different categories of perks!

EXPLORE THE LOCAL MAP

Find deals in your neighborhood with the local map!

Get Started Now!

revature.perkspot.com

To get started:

1. Sign up at **revature.perkspot.com**
2. When you're on your organization's PerkSpot site, click **"Create Your Account"** to get started.
3. Use access code: **RevaturePerks** to complete registration.

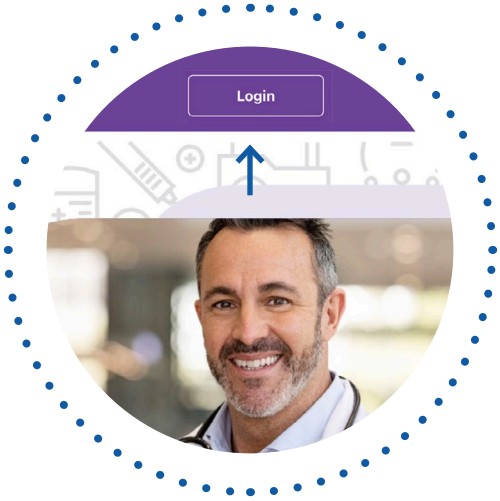
Employee Advocacy

Employee Advocacy starts here.

READY TO GET STARTED WITH **MYADVOCATE** FOR YOUR EMPLOYEES?

Get Tools and Resources to support installation of **MyAdvocate**.

STEP 1: CLICK LOGIN



STEP 2: ENTER YOUR CREDENTIALS

UN: mercer-employer

PW: m3Rc3R#3m9LoY

Get Started

Cigna Motivate*Me*

For Revature LLC Employees Enrolled in a Cigna Medical Plan

Good health may be its own reward, but a little extra bonus just sweetens the deal. Get rewarded for healthy behaviors through cash incentives year-round through Motivate*Me*.

You are an important part of the Revature Team and we care about your health and want to help you get healthy and stay healthy. We are now offering employees an incentive program to get you there through Cigna's MotivateMe Program.

HOW IT WORKS

When you participate in the health assessment and online coaching, you'll automatically earn rewards for completion. You are eligible to reach the maximum of $70 in rewards for healthy behaviors. The campaign is open year-round. The sooner you complete your healthy goals the sooner you can redeem your rewards in the form of gift cards of your choice.

How do you earn rewards that can be redeemed in the form of gift cards? You must complete the goals that will appear within myCigna. Please allow the health assessment goal 4 days to process and the online coaching goal 7–10 business days to process, before you can redeem rewards in the form of gift cards.

GETTING STARTED IS EASY

Log into **myCigna.com** > **Wellness** > click on **Wellness & Incentives** > scroll and click **View All Incentives**. There, you will find:

- A list of available healthy actions and earnings
- Details on how to get started **THEN IT'S UP TO YOU**.

START EARNING TODAY

Get healthy. Stay healthy. Do something good for yourself, and get something in return. It doesn't get much better than that.

For more information, or help setting up your account, call the Cigna customer service number found on the back of your Cigna ID card or call 1-800-Cigna24 or (800) 244-6224.

Please note that you must actively be employed by Revature LLC at the time of the incentive distribution in order to receive the reward. Gift/debit cards or other awards under your employer's incentive program may be considered taxable income.

Key Contacts

We encourage all Revature employees and their families to become familiar with and use the resources available to them. If you do not find what you need, please contact your group's plan administrator.

Revature HR Team
(E) **HR@Revature.com**

To assist with medical plan questions as employees make their decision on which plan to choose, **contact Cigna's Pre-Enrollment Advocate Line at (888) 806-5042.**

After Enrolling in Your Plan

It is highly recommended that you review your payroll deductions to make sure they match your benefit elections. Depending on your benefit elections you may or may not receive a new ID card. ID cards can take up to two weeks to arrive after the close of the enrollment period or the submission of your benefit elections.

BENEFIT	CARRIER/COMPANY	CUSTOMER SERVICE INFORMATION
Medical	Cigna	Group Number: 3344935 Customer Service Number: (866) 494-2111 Benefits Questions: (888) 806-5042 Rx Customer Service Number: (800) 835-3784 Website: **www.cigna.com**
Accident, Critical Illness, Hospital Indemnity	Cigna Supplemental	Group Number: AI111821, CI111753, HC111447 Customer Service Number: (800) 754-3207 Website: **www.SuppHealthClaims.com**
Dental	Guardian	Group Number: 434782 Customer Service Number: (800) 541-7846 Website: **www.guardiananytime.com**
Vision	EyeMed	Group Number: 1021301 Customer Service Number: (866) 800-5457 Website: **www.member.eyemedvisioncare.com/member**
Life, AD&D and Long-Term Disability	Guardian	Group Number: 434782 Customer Service Number: (800) 627-4200 Website: **http://www.guardiananytime.com**
Voluntary Term Life and AD&D	Guardian	Group Number: 434782 Customer Service Number: (800) 627-4200 Website: **www.guardiananytime.com**
Employee Assistance Plan	Uprise Health	Customer Service Number: (800) 386-7055 Website: **worklife.uprisehealth.com** Password: worklife
Dependent Care, Commuter Transit & Parking Benefits	iSolved	Group Number: 3A1396A Customer Service Number: (800) 796-7910 Website: **https://infinconsumer.lh1ondemand.com/Login.aspx**

It is important to remember that some plans offer limited or no coverage outside of the designated network. For this reason, we encourage all of our employees and their families to review the list of In-Network providers for each plan and benefit. Once you find a participating provider online it is also recommended that you call the provider's office and verify that they are still an In-Network provider, as online directories may not be current.

Additional Benefits

BENEFIT PROGRAM	OVERVIEW	CONTACT
Cigna – 24/7 Health Information Line	Your questions are important. And often urgent. That's why Cigna extended customer service hours. To better meet your needs 24 hours a day, 7 days a week, 365 days a year. Nights. Weekends. Holidays. We're here for you when you need us. Order an ID card, update insurance information and check claim status. Talk with a health advocate about your health goals and questions. Ask for a Spanish-speaking Cigna representative or receive translation in over 150 other languages.	Call the Member Services number on your ID card. Visit: **www.myCigna.com**
Cigna – Behavioral Health	For covered services related to mental health and substance abuse, you have access to the Cigna Behavioral Health network of providers. Telehealth visits with Cigna Behavioral Health network providers cost the same as an in-office visit.	**www.myCigna.com** or call the number on your ID card. Or you can go to **Cigna Behavioral Programs Total Behavioral Health** at **cignabehavioralprograms.com/CTBH/**
Cigna – Telehealth	Cigna partners with MDLIVE® for minor medical and behavioral/mental health virtual care.* Access care via video or phone. Get minor medical virtual care 24/7/365 – even on weekends and holidays. Schedule a behavioral/mental health virtual care appointment online in minutes. Cigna's in-network medical and behavioral providers also provide access to virtual medical and behavioral care, including virtual counseling. Board-certified doctors and pediatricians can diagnose, treat, and prescribe most medications for minor medical conditions. Licensed counselors and psychiatrists can diagnose, treat, and prescribe most medications for non-emergency behavioral conditions.	Call MDLive 24/7: 888-726-3171 Visit: **www.mdliveforcigna.com/landing/mdliveforcigna** or **www.myCigna.com** Search "MDLive" in your App Store or Google play.
Guardian – EAP Uprise Health	Balancing your work and home life is not always easy. With Uprise Health, your confidential employee assistance program, you don't have to face life's challenges along. Uprise Health provides support and guidance for matters that range from personal issues you might be facing to providing information on every day topics that affect your life. Support and guidance is just a phone call away.	Visit: **worklife.uprisehealth.com** Access code: worklife
Guardian – WillPrep	WillPrep Services are available to eligible members with Voluntary Life plan. Keep an up-to-date will is essential to ensuring that your assets are distributed as you intended, no matter the size of your estate.	For more information: **willprep.uprisehealth.com** Click on "No Cost Will Maker" at the top of the page, then click "Login" in the top right of the next page. New users will be required to create an account by clicking, "Register Now."

Reach out to HR or visit your benefits' webpage for additional information on the benefits listed on this page.

Required Federal Notices

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – MEDICAID

Website: **http://myalhipp.com/**
Phone: 1-855-692-5447

ALASKA – MEDICAID

The AK Health Insurance Premium Payment Program
Website: **http://myakhipp.com/**
Phone: 1-866-251-4861
Email: **CustomerService@MyAKHIPP.com**
Medicaid Eligibility: **https://health.alaska.gov/dpa/Pages/default.aspx**

ARKANSAS – MEDICAID

Website: **http://myarhipp.com/**
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – MEDICAID

Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322 Fax: 916-440-5676
Email: **hipp@dhcs.ca.gov**

COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)

Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: **https://hcpf.colorado.gov/child-health-plan-plus**
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – MEDICAID

Website: **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**
Phone: 1-877-357-3268

GEORGIA – MEDICAID

GA HIPP Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov programs/third-party-liability/childrens-health-insurance-program-reauthorization-act- 2009-chipra Phone:
678-564-1162, Press 2

INDIANA – MEDICAID

Health Insurance Premium Payment Program All other Medicaid Website:
http://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration Phone:
1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – MEDICAID AND CHIP (HAWKI)

Medicaid Website: **Iowa Medicaid | Health & Human Services**
Medicaid Phone: 1-800-338-8366
Hawki Website: **Hawki - Healthy and Well Kids in Iowa | Health & Human Services**
Phone: 1-800-257-8563
HIPP Website: **Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)**
HIPP Phone: 1-888-346-9562

KANSAS – MEDICAID

Website: **https://www.kancare.ks.gov/**
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – MEDICAID

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx**
Phone: 1-855-459-6328
Email: **KIHIPP.PROGRAM@ky.gov**
KCHIP Website: **https://kynect.ky.gov**
Phone: 1-877-524-4718
Kentucky Medicaid Website:
https://chfs.ky.gov/agencies/dms

LOUISIANA – MEDICAID

Website:
www.medicaid.la.gov or **www.ldh.la.gov/lahipp**
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – MEDICAID

Enrollment Website: **https://www.mymaineconnection.gov/benefits/s/?language=en_US**
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – MEDICAID AND CHIP

Website: **https://www.mass.gov/masshealth/pa**
Phone: 1-800-862-4840 TTY: 711
Email: **masspremassistance@accenture.com**

MINNESOTA – MEDICAID

Website: **https://mn.gov/dhs/health-care-coverage/** Phone: 1-800-657-3672

MISSOURI – MEDICAID

Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm**
Phone: 573-751-2005

MONTANA – MEDICAID

Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP**
Phone: 1-800-694-3084
Email: **HHSHIPPProgram@mt.gov**

NEBRASKA – MEDICAID

Website: **http://ACCESSNebraska.ne.gov**
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – MEDICAID

Medicaid Website: **http://dhcfp.nv.gov**
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – MEDICAID

Website: **https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program**
Phone: 603-271-5218
Toll free number for the HIPP program:
1-800-852-3345, ext. 15218
Email: **DHHS.ThirdPartyLiabi@dhhs.nh.gov**

NEW JERSEY – MEDICAID AND CHIP

Medicaid Website: **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/**
Phone: 800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: **http://www.njfamilycare.org/index.html**
CHIP Phone: 1-800-701-0710 (TTY:711)

NEW YORK – MEDICAID

Website:
https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

NORTH CAROLINA – MEDICAID

Website: **https://medicaid.ncdhhs.gov/**
Phone: 919-855-4100

NORTH DAKOTA – MEDICAID

Website: **https://www.hhs.nd.gov/healthcare**
Phone: 1-844-854-4825

OKLAHOMA – MEDICAID AND CHIP

Website: **http://www.insureoklahoma.org**
Phone: 1-888-365-3742

OREGON – MEDICAID

Website:
http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – MEDICAID AND CHIP

Website: **https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html**

Phone: 1-800-692-7462

CHIP Website: **Children's Health Insurance Program (CHIP) (pa.gov)**
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – MEDICAID AND CHIP

Website: **http://www.eohhs.ri.gov/**
Phone: 1-855-697-4347, or 401-462-0311
(Direct RIte Share Line)

SOUTH CAROLINA – MEDICAID

Website: **https://www.scdhhs.gov**
Phone: 1-888-549-0820

SOUTH DAKOTA - MEDICAID

Website: **http://dss.sd.gov**
Phone: 1-888-828-0059

TEXAS – MEDICAID

Website: **Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services**
Phone: 1-800-440-0493

UTAH – MEDICAID AND CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: **https://medicaid.utah.gov/upp/** Email: **upp@utah.gov** Phone: 1-888-222-2542 Adult Expansion Website: **https://medicaid.utah.gov/expansion/** Utah Medicaid Buyout Program Website: **https://medicaid.utah.gov/buyout-program/** CHIP Website: **https://chip.utah.gov/**
VERMONT– MEDICAID
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – MEDICAID AND CHIP
Website: **https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select** **https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs** Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – MEDICAID
Website: **https://www.hca.wa.gov/** Phone: 1-800-562-3022
WEST VIRGINIA – MEDICAID AND CHIP
Website: **https://dhhr.wv.gov/bms/** **http://mywvhipp.com/** Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – MEDICAID AND CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – MEDICAID
Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/** Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

IMPORTANT NOTICE TO EMPLOYEES FROM REVATURE ABOUT CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Revature medical plan are expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2026. This is known as "creditable coverage."

Why this is important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2026 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with Revature and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

NOTICE OF CREDITABLE COVERAGE

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the Revature prescription drug plans you'll be interested to know that the prescription drug coverage under the plans is, on average, at least as good as standard Medicare prescription drug coverage for 2026. This is called creditable coverage. Coverage under [one of] these plan[s] will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

Cigna OAP

Cigna OAP HSA

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the Revature plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Revature coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment or other qualifying event, or otherwise become newly eligible to enroll in the Revature plan mid-year, assuming you remain eligible.

You should know that if you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this Revature coverage changes, or upon your request.

More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

Visit **www.medicare.gov** for personalized help.

Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number) or visit the program online at **https://www.shiptacenter.org/**.

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at **www.socialsecurity.gov** or call 1-800-772-1213 (TTY 1-800-325-0778).

For more information about this notice or your prescription drug coverage, contact:

Vivian Zegarra
HRIS, Manager
CorporateHR@revature.com

NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR HEALTH PLAN COVERAGE

As you know, if you have declined enrollment in Revature's health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plan without waiting for the next open enrollment period, provided that you request enrollment within 30days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

- Revature will also allow a special enrollment opportunity if you or your eligible dependents either:
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the Revature group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at **HR@Revature.com**.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, contact your plan administrator at **HR@Revature.com**.

HIPAA PRIVACY NOTICE REMINDER

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require the Revature (the "Plan") to periodically send a reminder to participants about the availability of the Plan's Privacy Notice and how to obtain that notice. The Privacy Notice explains participants' rights and the Plan's legal duties with respect to protected health information (PHI) and how the Plan may use and disclose PHI.

To obtain a copy of the Privacy Notice contact Human Resources Benefits Team at **HR@Revature.com**.

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