2022 Employee Benefits Guide

Revature Associates & Software Engineers

Because Good Health Is Everything

Take control of your benefits today!

Review this guide. It includes details on all of your benefit options.

After reviewing the benefit options, select the coverage that fits best for you and your family.

Complete the necessary steps to enroll in the coverage you select.

REVATURE

What's inside...

BBG – Our role and our commitment:

BBG works with your management team to review available options, benchmarking data, and advocates for the best available coverage and premium rates.

BBG is here to support you throughout the year should you encounter billing or claims related issues. If you experience such issues, please contact your Human Resources department to obtain our contact information.

BBG partners with more than 900 employer groups in the Washington, DC metropolitan area, and has been supporting these efforts for over 20 years. We are committed to doing everything within our power to ensure you have a positive experience with your benefits package.

BUSINESS BENEFITS GROUP

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

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 open enrollment or the submission of your benefit elections.

Benefit	Carrier/Company	Customer Service Information
Medical	Cigna	Group Number: 3344935 Customer Service Number: (866) 494-2111 RX Customer Service Number: (800) 835-3784 Website: www.cigna.com
Dental	Guardian	Group Number: 434782 Customer Service Number: (800) 541-7846 Website: www.guardiananytime.com
Vision	EyeMed	Group Number: 624822 Customer Service Number: (888) 203-7437 Website: www.eyemed.com
Life, AD&D, Long and Short 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	Guardian	Customer Service Number: (800) 386-7055 Website: www.ibhworklife.com Password: Matters
Dependent Care, Commuter Transit & Parking Benefits	PrimePay	Group Number: PRINP8340 Customer Service Number: (877) 769-3539 Website: www.primepay.com
Behavioral Health	MeMD	Customer Service Number: (855) 636-3669 Download App: www.MeMD.me/app-store Plan Code: BYT2MVBK
Business Benefits Group	Customer Service for all benefits and claims questions	Phone: (703) 385-7200 / x283 Email: service@bbgbroker.com

Finding a Doctor

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.

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 Plans provided by Cigna—**NEW!**
- Dental Plan provided by Guardian
- Vision Plan provided by EyeMed
- Life and AD&D insurance provided by Guardian
- Voluntary Term Life, AD&D and Long Term Disability insurance provided by Guardian
- Additional Benefits provided by Cigna and Guardian
- Dependent Care, Commuter Transit & Parking Benefits provided by PrimePay
- Behavioral Health Benefits provided by MeMD

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 pre-tax 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 for Benefits

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

When your Coverage Ends

Your coverage will end on the last day of the month of your date of termination, unless it encompasses Employer Paid benefits such as Life or Disability which 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 co-pays, 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.

Individual Mandate!

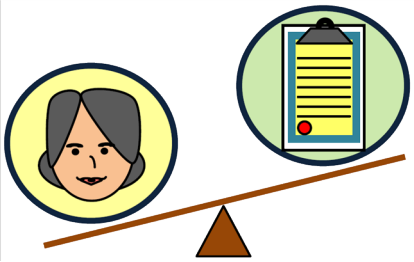
Beginning with the 2019 tax year, the individual Mandate provision of the Affordable Care Act will end; however, several states have passed laws that require residents to purchase health insurance or pay a penalty. Be sure to consider any local or state requirements during Open Enrollment.

Key Terms

Deductible

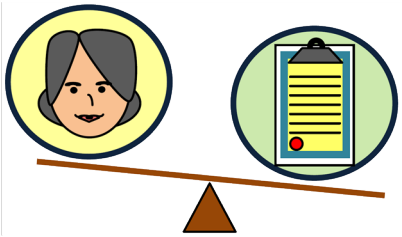
The amount that must be paid per benefit period before insurance begins to pay its portion of claims. The deductible amount may vary based on whether it is individual or family coverage.

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.

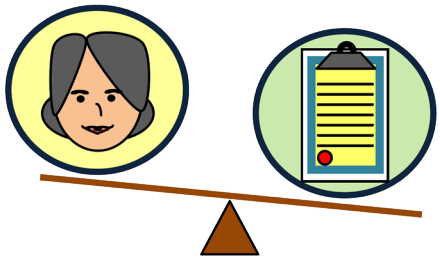
Copayment

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

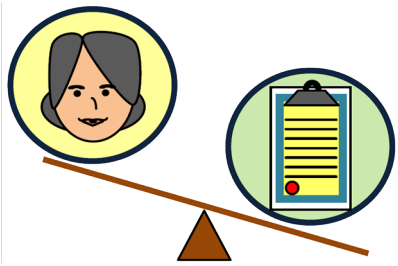
The maximum amount a member will pay out-of-pocket during the benefit period. This amount includes deductibles, coinsurance and copayments. Once the out of pocket maximum is met, the insurer will pay 100% of the allowed amount for covered services, for the remainder of the benefit period.

Out of Pocket Maximum



Jane pays 0% **Her plan pays 100%**

Out of Network / Balance Billing



Jane pays 20% **Her plan pays 80%**

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 500**	**National OAP HSA**
Doctor Co-Pay (PCP/Specialist)	$20/$20	Ded + Coins
Deductible (Individual/Family)	$500/$1500	$1500/$3000
Coinsurance (Insurance/Member)	80%/20%	80%/20%
Inpatient Hospitalization	Ded + Coins	Ded + Coins
Outpatient Surgery (PCP/ Specialist)	Ded + Coins	Ded + Coins
Physical Therapy	Ded + Coins / 30 visits max	Ded + Coins / 30 visits max
Mental Health	Ded + Coins	Ded + Coins
Lab / X-Ray / Advanced Diagnostics	Ded + Coins	Ded + Coins
Urgent Care	$20 Copay	Ded + Coins
Emergency Room	$150 Copay	Ded + Coins
Out-of-Pocket Maximum (Ind/Fam)	$2400/$7200	$3000/$6000
OUT-OF-NETWORK		
Deductible (Individual/Family)	$900/$2700	$3000/$6000
Coinsurance (Insurance/Member)	60%/40%	60%/40%
Out-of-Pocket Maximum (Ind/Fam)	$6850/$13700	$6000/$12000
COVERED PRESCRIPTIONS		
Deductible	$0	Combined w/med
Retail (Tier 1/Tier 2/Tier 3)	$15/$35/$60	Ded + Coins
Mail-Order (Tier 1/Tier 2/Tier 3)	$30/$70/$120	Ded + Coins
Tier 4 (Specialty)	50% up to $100	Ded + Coins
Monthly Deductions		
Employee Only	$105.54	$72.64
Employee + Spouse	$443.27	$361.41
Employee + Child(ren)	$401.05	$326.99
Employee + Family	$580.47	$473.27

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 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. HealthCare 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.

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.

Contribution Limit (employer + employee)	2022
Single	$3,650
Family	$7,300
Catch-Up (55+) (Single or Family)	$1,000

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.

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

What about my FSA?

Participation in an HSA restricts your enrollment to a limited purpose FSA. A limited-purpose health flexible spending account (referred to as a limited-purpose FSA) is much like a typical, general-purpose health FSA. However, under a limited-purpose FSA, eligible expenses are limited to qualifying dental and vision expenses for you, your spouse, and your eligible dependents.

Please note: the HSA contribution limit is tracked by calendar year, not Revature’s plan year.

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	$46,500
Estimated Tax Rate	($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 co-pays, 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.*

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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.

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.

Dental Benefits

Guardian Dental Plan

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
Open Enrollment	Annual	Annual
Monthly Deductions		
Single	$22.36	$35.45
Employee + Spouse	$44.51	$70.56
Employee + Child(ren)	$52.89	$102.91
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 19.

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. HealthCare 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

EyeMed Vision Plan

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	$5.45
Employee + Spouse	$10.34
Employee + Child(ren)	$10.89
Family	$16.01

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 healthcare 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

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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.

Voluntary Long Term Disability**

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.

**Premium rates are available in the ADP enrollment system. Rates will be based on age.

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.

Life and AD&D	
Benefit Amount	$50,000
Voluntary Term Life	
Employee Benefit Amount	Up to $150,000 not to exceed 5x employee annual salary
Employee Guaranteed Issue	$150,000
Spouse Benefit Amount	Up to $25,000 not to exceed 50% of employee coverage
Spouse Guaranteed Issue	$25,000
Dependent Children Amount	$2,000 to $10,000 not to exceed 10% of employee coverage
Dependent Children Guaranteed Issue	$10,000
AD&D Benefits	Matches Life
*** Please note that guarantee 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.**	
Voluntary 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

Dependent Care Benefits

PRIMEPAY

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.

Eligible Expenses

For more information about eligible transportation expenses, please refer to IRS Publication 15-B available at https://www.irs.gov/publications/p15b/ar02.html#en_US_2016_publink1000193740.

What is a Dependent Care FSA?

- A Dependent Care FSA (DCFSA) is a pre-tax 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.

What are the benefits of an FSA?

- It **saves you money**. An FSA is an employer-sponsored savings account that allows you to put aside money tax -free to be used to pay for qualified medical, dependent care, and transportation expenses.
- It is a **tax-saver**. Contributions to your FSA are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you pay less in taxes.
- It is **flexible**. You can withdraw health FSA funds at any time for qualified medical expenses, even if it’s only the beginning of the year and you haven’t contributed the entire yearly amount yet.

Features of the FSA plan	
Plan year	02/01/22 - 1/31/23
Dependent Care Max	$5,000
You must re-enroll annually - No Exceptions!	

Commuter Transit & Parking Benefits

The 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 - $280 per month
- Qualified Parking - $280 per month

Eligible Expenses

For more information about eligible transportation expenses, please refer to IRS Publication 15-B available at https://www.irs.gov/publications/p15b/ar02.html#en_US_2016_publink1000193740.

What is a Commuter Transit Benefit?

- A Commuter Transit Benefit is a pre-tax 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 $280 per month on a pre-tax 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.

What is a Commuter Parking Benefit?

- A Commuter Parking Benefit is a pre-tax 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 $280 per month on a pre-tax 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.

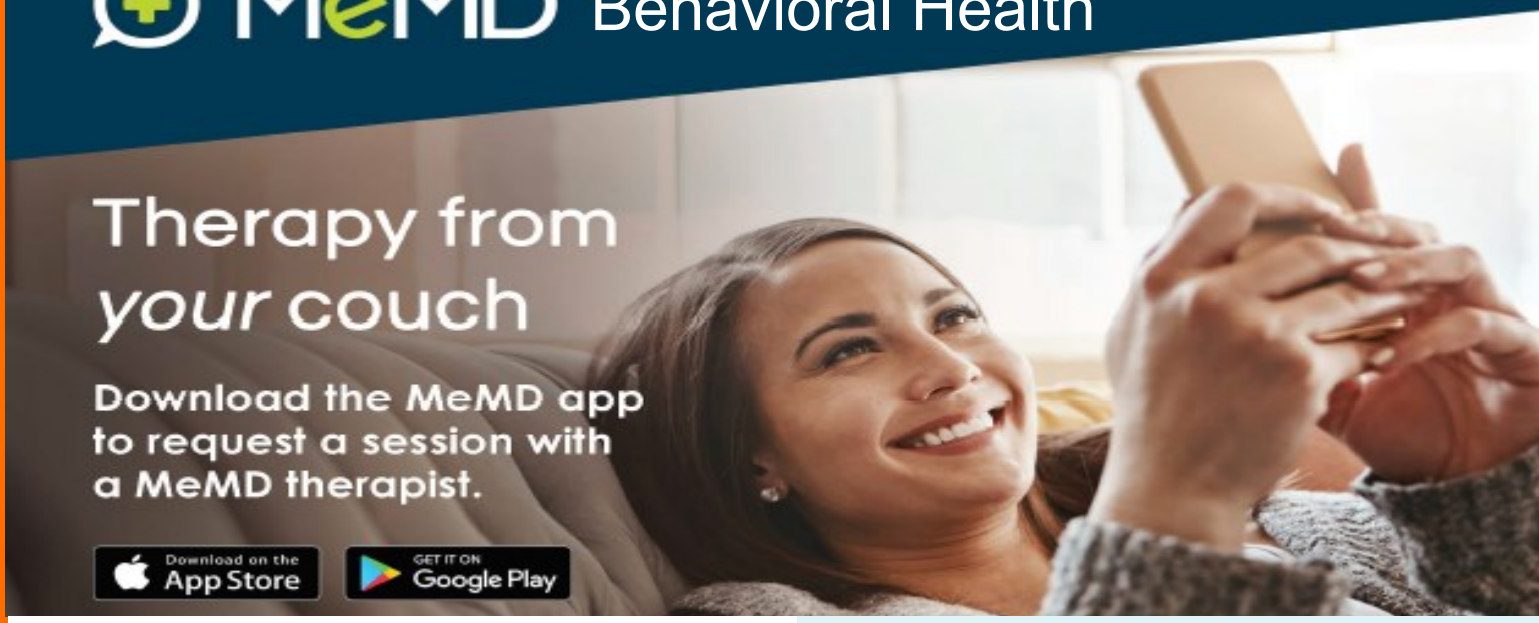
How does it work?

http://www.mybenefitfunds.com/primeflex/

- You will need to complete your enrollment via the ADP 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 a PrimePay FLEX 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.
- PrimePay 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.

Features of the FSA plan	
Plan year	02/01/22 - 1/31/23
Parking and Transit	$280 per month each
You must re-enroll annually - No Exceptions!	

MeMD Behavioral Health



FEEL BETTER FASTER

1 SIGN IN TO MeMD

Access your MeMD account by downloading the app and entering your plan code when prompted:

Visit: www.MeMD.me/app-store

Plan Code: BYT2MVBK

2 REQUEST AN EXAM

For non-emergency health issues, you can request an exam using your phone, tablet or computer.

3 SPEAK WITH A PROVIDER

Your MeMD Provider will review your chart, ask questions, and recommend a treatment plan.

When to use MeMD

It can be difficult to wait days or weeks for an appointment. With on-demand therapy from MeMD, you can speak with a therapist in as little as 48 hours for concerns like:

- Relationships, divorce, parenting issues
- Anger management
- Addiction, eating disorders
- Bipolar disorder, ADHD/ADD
- Anxiety & stress
- Depression, mood, grief & loss
- Abuse, domestic violence
- General counseling and more

$20.00 *per visit*

Who will you see?

The MeMD medical team includes experienced and accredited therapists who are licensed to practice in your state.

Questions? 855-636-3669 | helpdesk@memd.me

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Not a Member? Sign up!

Go to the ADP Portal home page and click on the rotating LifeMart banner to access immediate discounts OR select **Myself** > **Benefi ts** > **Employee Discounts** > **LifeMart**

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.	Visit: www.Cignabehavorial.com
Cigna - RecoveryOne	RecoveryOne™ for Cigna® is an online physical therapy program that's included in your health plan benefits. There's no added cost to you or your covered dependents (ages 18+) to use it.* Online PT you can do when you want, from the comfort and safety of home. Customized recovery plans to meet your needs. A multimedia app that guides you through your exercises. Video, voice, and chat conversations with your support team. Weekly check-ins with a certified health coach to help keep you on track.	Visit: www.startptonline.com
Cigna - Telehealth	Cigna partners with MDLIVE® for minor medical and behavioral/ mental health virtual care.* Access care from just about anywhere 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 nonemergency behavioral conditions.	Call MDLive 24/7: 888-726-3171 Visit: www.MDLIVEforCigna.com or www.myCigna.com Search "MDLive" in your App Store or Google play.
Guardian - EAP WorkLifeMatters	Balancing your work and home life is not always easy. With WorkLifeMatters, your confidential employee assistance program, you don't have to face life's challenges along. WorkLifeMatters 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.	Connect to a counselor for free support services: (800) 386-7055 Available 24 hours a day, 7 days a week Visit: www.ibhworklife.com Password: Matters
Guardian - College Tuition Services	Welcome to the College Tuition Benefits Rewards program! You can use your College Tuition Benefits Rewards at over 340 private colleges and universities across the nation. You will receive 2,000 rewards for each year you have Guardian Dental Plan benefits. Each Tuition Reward point equals a $1 tuition reduction. Tuition Rewards can be given to your relatives including children, nephews, nieces and grandchildren.	To learn more: www.guardian.collegetuitionbenefit.com Or call (215) 839-0119
Guardian - Will Prep	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: www.ibhwillprep.com User Name: WillPrep Password: GLIC09

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

Required Federal Notices

IMPORTANT PATIENT PROTECTION AND AFFORDABLE CARE ACT NOTICES, ERISA NOTICES AND CONTACTS FOR MORE INFORMATION

The notices in this package describe important rights that you have under the terms of the Revature Group Health Plan. If you have any questions or need additional information regarding these notices you can contact:

Your Employer Representative: Revature HR Team /(703) 372-0300 / HR@Revature.com

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NMHPA)

The Newborns' Act, and its regulations, provides that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier. The Newborns' Act, and its regulations, prohibits incentives (either positive or negative) that could encourage less than the minimum protections under the Act as described above. A mother cannot be encouraged to accept less than the minimum protections available to her under the Newborns' Act, and an attending provider cannot be induced to discharge a mother or newborn earlier than 48 or 96 hours after delivery.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Contact your Employer Representative for more information.

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 lymphedemas.

These benefits will be provided subject to the same deductible and co-insurance particulars that are applicable to other medical and surgical benefits provided under this Plan. Revature, LLC has provided the detailed information regarding deductible and co-insurance for the Revature, LLC Group Health Plan. For more information or to get a copy of the Summary Plan Description containing these details contact your Employer Representative.

NOTICE OF PRIVACY PRACTICES

Protecting the confidentiality of your personal medical information has always been an important priority. We continue to maintain policies to safeguard the privacy of your medical information and comply with federal law (specifically, "HIPAA" and the privacy rules issued under HIPAA). We are required by federal law to protect the privacy of your individual health information (referred to in this reminder as "Protected Health Information"). We are also required to provide you with this reminder regarding our policies and procedures on your Protected Health Information. For more information about your privacy rights or to request a copy of the Health Plan's Notice of Privacy Practices contact your Employer Representative. The Notice of Privacy Practices provides detailed information on how the Health Plan may use your information as well as what rights you have regarding that information.

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 any of the 50 States or the District, contact your State Medicaid or CHIP office to find out if premium assistance is available: http://www.insurekidsnow.gov/.

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 http://www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

*OMB Control Number 1210-0137 (expires 12/31/2019)

HIPAA SPECIAL ENROLLMENT RIGHTS NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). 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 dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your Employer Representative.

PATIENT PROTECTION CHOICE OF PROVIDERS

In cases where the Revature, LLC Group Health Plan allows or required a participant to designate a primary care provider, the participant has the right to designate any primary care provider who participates in the network and who is available to accept the participant or participant's family members.

Until you make this designation, Revature, LLC Group Health may designate a primary care provider automatically. For information on how to select a primary care provider, and for a list of the participating primary care providers, you can contact your Employer Representative. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Revature, LLC Group Health Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer Representative

www.BBGbroker.com

The Business Benefits Group presents this informational package as a service to our clients and their employees. While the information provided is regarding your company benefit offerings, this is not a legal document and should not be construed as a contract or a guarantee of coverage. Moreover, due to the rapidly changing environment of healthcare and our reliance on the Insurance Carriers to provide accurate information, we make no warranty or guarantee concerning the accuracy or reliability of the content of this informational package. It is solely the employers responsibility what information is communicated and the accuracy of such. No enrollments or elections are final until they have been submitted and approved by the Insurance carrier.