GT GreenbergTraurig

2026 BENEFITS GUIDE

For Benefits Effective January 1 – December 31, 2026

What's Inside

New for 2026!

Below is an outline of the changes to our benefit plans.

Medical Plan Changes for 2026

All Plans:

- Reimbursement for trained doula service expenses, up to $2,500 per pregnancy
- Preventive services are expanding to cover the following services at 100%:
  - Skin cancer screenings
  - Diagnostic breast cancer screenings

Network Plan:

- Preventive services are expanding to annually cover your first diagnostic colonoscopy at 100%, even after a preventive colonoscopy
- A non-preferred brand name drug (tier 3) copay is being added

Tiered Plan:

- Out-of-Pocket maximums increase to match HSA maximum increase

One Step Plan (enrollment is limited to current plan participants only):

- In-Network and Out-of-Network deductibles and In-Network Out-of-Pocket maximums increase to match HSA maximum increase

New Pharmacy Benefit Manager

Beginning January 1, 2026, Capital Rx will be our new pharmacy provider, replacing CVS Caremark. As part of this change, mail order prescriptions will be filled through Costco.

Health Savings Account

- Contribution maximums increase to $4,400 Individual / $8,750 Family
- Catch-up contributions for those age 55 and up, or turning age 55 in 2026, remain at $1,000

Flexible Spending Accounts (FSAs)

- The Dependent Care FSA maximum is increasing to $7,500 ($3,750 if married and filing separate tax returns)
- Make your election for 2026. **You MUST make new FSA elections each year as elections do not roll over.** Although 2026 IRS limits haven't been released for the health care FSAs, you can elect up to the predicted maximum during open enrollment. If you elect the maximum and IRS limits are less than predicted, we will automatically adjust your election to the IRS maximums.

This Open Enrollment Guide is a brief overview of the benefits offered in 2026. Visit http://gtworkday.gtlaw.com to access our comprehensive benefits website.

Additional resources for Open Enrollment can be found on our Online Benefits Website:

- 2026 Calendar of Open Enrollment Webinars and Events
- 2026 Open Enrollment Presentation
- Medicare Overview

Eligibility & Enrollment

ELIGIBILITY

Benefits-eligible U.S. employees scheduled to work a minimum of 30 hours per week are eligible to enroll in Greenberg Traurig ("GT") benefits.

Before enrolling eligible dependent family members, you must first be enrolled in a GT benefits plan, either as an employee or, if your spouse or domestic partner is covered under a GT plan, as a dependent. If you and your spouse or domestic partner are both covered under a GT plan, only one parent can enroll your child(ren) as dependents.

ELIGIBLE DEPENDENTS

- Your legal spouse
- Your domestic partner*
- Your child(ren) through the end of the plan year in which they attain age 26
- Your spouse's child(ren) through the end of the plan year in which they attain age 26 (including natural, step and legally-adopted children, a child placed for adoption or a child for whom you or your spouse is the legal guardian)
- Enrolled domestic partner's children through the end of the plan year in which they attain age 26
- Child covered under Qualified Medical Child Support Order or other court or administrative order
- Your unmarried, disabled child dependent upon you for support, currently covered under your GT medical plan (verifying medical documentation is required)

*You must submit an affidavit if you would like to enroll an eligible domestic partner in GT benefits coverage.

INELIGIBLE DEPENDENTS

Ineligible dependents include, but are not limited to, parents, grandparents, grandchildren (unless you're their legal guardian), siblings, ex-spouses, and ex-domestic partners. Talk to your HR representative or email **hrbenadmin@gtlaw.com** if you have questions about whether a dependent is eligible for coverage.

HOW TO ENROLL

Log into **http://gtworkday.gtlaw.com** by desktop, laptop, or tablet.

As you enroll, make sure to:

- Verify your dependents' eligibility for coverage
- Update your beneficiary information, as needed
- Have birth dates and Social Security Numbers available to add new dependents
- Review birth dates and Social Security Numbers for current dependents and update if necessary.

Medical Benefits

UnitedHealthcare (UHC)

GT offers you medical plans options administered through UnitedHealthcare (UHC). **Below is a comparison of the medical plan benefits.** For more detailed descriptions of each plan, visit the Plan Documents page on the Benefits Home Page in GTWorkday at http://gtworkday.gtlaw.com. Plan changes in **bold** below.

	NETWORK PLAN	TIERED PLAN		ONE STEP PLAN (CLOSED TO NEW ENTRANTS)	
BENEFITS	In-Network Only	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Calendar Year Deductible (Ded.)	$750 Ind / $1,500 Fam	$2,500 Ind / $5,000 Fam	$4,000 Ind / $8,000 Fam	**$4,400 Ind / $8,750 Fam**	**$4,400 Ind / $8,750 Fam**
Out-of-Pocket Maximum	$2,000 Ind / $4,000 Fam	**$4,400 Ind / $8,750 Fam**	$6,000 Ind / $12,000 Fam	**$4,400 Ind / $8,750 Fam**	$6,000 Ind/ $12,000 Fam
Coinsurance (you pay)	20%	10% or 20%	30%	0%	30%
Preventive Care	No charge	No charge	30% after ded.	No charge	30% after ded.
Primary Care Physician (PCP) / Specialist	Tier 1 PCP: $25 copay Tier 2 PCP: $50 copay Tier 1 Specialist: $50 copay Tier 2 Specialist: $75 copay	Tier 1: 10% after ded. Tier 2: 20% after ded.	30% after ded.	0% after ded.	30% after ded.
Virtual Visits	$25 copay	10% after ded.	Not Covered	0% after ded.	Not covered
Urgent Care	$75 copay	20% after ded.	30% after ded.	0% after ded.	30% after ded.
Emergency Room	$500 copay	20% after ded.	20% after ded.	0% after ded.	0% after ded.
OT, PT, Speech Therapy	$75 copay	20% after ded.	30% after ded.	0% after ded.	30% after ded.
Fertility/Infertility	Not covered	$35,000 lifetime maximum, including Rx.**	Not covered	$35,000 lifetime maximum, including Rx.**	Not covered
Diagnostic and Labs	20% after ded.	20% after ded.	30% after ded.	0% after ded.	30% after ded.
Hospital Inpatient / Outpatient	$500 copay, then 20% after ded.	20% after ded.	30% after ded.	0% after ded.	30% after ded.

* Out-of-network providers may be reimbursed differently than In-network providers. This may result in higher out-of-pocket costs for you including "balance billed" amounts that do not apply to your plan deductible or plan out-of-pocket maximum.

** Requires use of Optum Fertility Solutions. See plan details for more information.

Medical Benefits
UnitedHealthcare (UHC)

If you need assistance with mental health concerns, confidential virtual visits can help with:

- Anxiety
- Depression
- Stress
- ADD/ADHD
- Addiction
- Relationship Issues
- And Much More

UHC VIRTUAL CARE BENEFITS AND CAPABILITIES

If you have cold or flu symptoms, a sore throat, sinus infection, allergy, rash or other non-emergency illness, you may be able to skip the doctor's office and receive medical care from the comfort of your home through Virtual Visits.

	24/7 VIRTUAL VISITS	VIRTUAL PRIMARY CARE	TELEHEALTH VIA EXISTING PHYSICIAN/PROVIDER
Similar To	Urgent Care	Primary Care	Your Doctor
Description	Connect to a doctor by phone or video through myuhc.com or the UnitedHealthcare app. Doctors can treat a wide range of health conditions, from flu and pinkeye to migraines and more, and can even prescribe medication as needed. 24/7 Virtual Visits may treat many of the same conditions as in-person urgent care, so it may be a good alternative option for employees – particularly in times when their primary care provider isn't available. 24/7 Virtual Visits is its own defined benefit.	Delivers many of the same services as traditional primary care. Services may include: Preventive and regular exams Management of chronic conditions Acute non-emergency needs It combines convenience with the potential advantages of seeing a provider regularly who knows your health history.	Real-time, remote (tele) interaction between physician and patient. Local providers and primary care physicians may have virtual care options available. Visits provided through video or telephone can be helpful for a variety of care needs, including routine medical care.
Cost	**Network Plan:** $25 copay. **Tiered Plan:** $49 fee (applies to deductible), then 20% cost share after deductible has been met. **One Step Plan:** $49 fee (applies to deductible), then covered 100% after deductible has been met The cost is typically less than going to the doctor's office, urgent care or emergency room.	**Network Plan:** $25 copay per visit by a Designated Virtual Network Provider. **Tiered Plan:** $49 (visits that are 15 minutes or less) or $99 (visits that are more than 15 minutes), then 10% cost share after deductible has been met. **One Step Plan:** $49 (visits that are 15 minutes or less) or $99 (visits that are more than 15 minutes), , then covered 100% after deductible has been met.	Same cost as a visit to the provider in-person depending on the type and tier of the provider utilized (PCP, Specialist, etc.). See plan details for more information.
Access	Choose from 3 national providers (Teladoc, Doctor On Demand and Amwell). Optum Virtual Care and Teladoc physicians are accessible via single sign-on from myuhc.com or the UnitedHealthcare app.	Accessible via single sign-on from myuhc.com or the UnitedHealthcare app.	Accessible from local care providers and physicians.

Medical Benefits

UnitedHealthcare (UHC)

WHERE TO SEEK CARE

With so many options for care, how do you know which is best for the flu, a broken bone or physical exam? Depending upon where you receive medical attention, the cost can vary immensely. Here's a general guideline that can help you save time and money.

LOCATION OF CARE	COST	COMMON CONDITIONS	TIME INVESTMENT
Virtual Visits 	$	• Allergies • Bladder infections • Cough / cold / sinus / flu • Behavioral health needs • Pink eye • Diarrhea	• Appointments typically available within an hour • No need to leave home
Primary Care Physician 	$$	• Checkups • Preventive services • Vaccinations and screenings • General health management • Sick visits for minor conditions	• Usually need appointment • Short wait times • Telemedicine often available as well
Urgent Care 	$$/$$$	• Fever and flu symptoms • Sprains and strains • Stitches • Minor burns • Minor infections • Minor broken bones	• No appointment needed • May have extended hours
Emergency Room 	$$$$	• Heavy bleeding • Large open wounds • Sudden vision change • Chest pain • Spinal or head injuries • Major broken bones • Severe cuts / burns • Numbness or weakness	• Open 24/7 • Wait times can be up to several hours

Prescription Benefits

Capital Rx

Below is an overview of the prescription benefits. Use your Capital Rx ID card at the pharmacy to access benefits.

	NETWORK PLAN	TIERED PLAN	ONE STEP PLAN (CLOSED TO NEW ENTRANTS)
	In-Network		
Deductible	No deductible	Medical deductible applies (excludes preventive care medications)	Medical deductible applies
Prescriptions at a Retail Pharmacy (30-day supply) Generic / Preferred Brands / Non-preferred brands	Copays: $12 / $60 / $100	Copays: $10 / $50 / $100	Plan pays 100% after deductible
Copays for Mail Order (90-day supply)	Copays: $24 / $120 / $200	Copays: $20 / $100 / $200	Plan pays 100% after deductible
Costco Specialty Pharmacy Medications (30-day supply)*	Copays: $12 / $60 / $100	Copays: $10 / $50 / $100	N/A
Human Growth Hormone Medication	Not covered	Covered 50% after deductible until out-of-pocket maximum is reached, then covered 100%. Prior authorization required.	Covered 50% after deductible until out-of-pocket maximum is reached, then covered 100%. Prior authorization required.
Infertility Medication	Not covered	Covered 50% after deductible until out-of-pocket maximum is reached, then covered 100%. $10,000 lifetime Rx maximum. Prior authorization may be required.	Covered 50% after deductible until out-of-pocket maximum is reached, then covered 100%. $10,000 lifetime Rx maximum. Prior authorization may be required.

* Must use Costco Special Pharmacy specialty prescription drug card program.

To find an in-network pharmacy, visit **app.cap-rx.com/register** and register or log in. For formulary information, please email **hrbenadmin@gtlaw.com**.

Prescription Benefits

Capital Rx

PRESCRIPTION BENEFITS

Our three medical plans include prescription drug benefits through Capital Rx. You can get up to a 30-day supply at any retail pharmacy in the network. Just present your Capital Rx ID card and make the required payment. Covered drugs are listed on the plan's drug list, also known as the formulary.

- **Network Plan** – You pay a copay for each prescription you fill. You're responsible for the difference in cost if you choose a brand name over a generic prescription. There's no coverage for fertility/infertility or human growth hormone medication.
- **Tiered Plan** – Prescription drugs are covered after you meet the medical plan's annual deductible. There is no separate prescription drug deductible. However, you are responsible for copays and the difference in cost if you choose a brand name over a generic prescription. The plan's annual deductible is waived for preventive medications.
- **One Step Plan** – Once you meet your deductible, GT covers eligible prescription drugs 100%. All prescription medications, including non-ACA preventive drugs, are subject to the deductible. If you choose to get a brand-name drug, you will be responsible for the difference in cost between that drug and the less-expensive generic alternative.

To find an in-network pharmacy, visit **app.cap-rx.com/register** and register or log in. For formulary information, please email **hrbenadmin@gtlaw.com.**

Step Therapy

GT medical plans include drug management programs to ensure you receive, safe, cost-effective medications. You and your health care provider may be asked to try a more cost-effective, therapeutically appropriate medication before progressing to a more costly option. Additionally, your provider may be asked for more information or prior authorization before certain drugs are approved.

Maintenance Medications

If you are prescribed a maintenance medication (e.g. long-term conditions like arthritis, asthma, diabetes, high blood pressure or high cholesterol), you can fill your 30-90 day prescription at retail pharmacies or through mail service by visiting **rx.costco.com**.

UHC Enhanced Resources

ABLETO

AbleTo provides virtual support for the depression, anxiety and stress that typically may accompany health issues such as cardiac conditions, diabetes, chronic pain and cancer. AbleTo engages employees in behavioral coaching via phone or video, once a week for up to eight weeks. The program can help:

- Identify high-risk employees early
- Connect one-on-one with employees in need
- Personalize care delivery
- Treat behavioral health using a holistic approach

CALM HEALTH

Calm Health is available through your UHC behavioral health benefits at no additional cost to you. The app is filled with self-paced programs, courses, and tools that are designed to strengthen the connection between your body and your mind. Once you complete a short screening, Calm Health will create a personalized experience for you, as well as provide recommendations for additional solutions and services through your health plan. To get started, download the Calm Health app, and enter your United Healthcare member ID, name, and date of birth.

CENTERS OF EXCELLENCE (COEs)

COEs use evidence-based protocols to deliver cost-effective care for complex medical procedures at leading treatment centers. When you seek care from a COE, you'll benefit from its rigorous review process and criteria, deep savings, improved outcomes, dedicated support from specialized clinicians and lower rates of readmission and post-surgical complications. Call the number on the back of your UHC ID card to enroll. COE is required for the following programs:

- Fertility Solutions (Tiered and One Step plans only)
- Transplants
- Bariatrics (Tiered and One Step plans only)

CHILD AND FAMILY BEHAVIOR HEALTH COACHING

Behavioral Health Coaching is available through Bend Health at no additional cost to families with children ages 1-17. It offers support from an experienced coach, up to four 45-minute sessions per month, unlimited messaging with your coach, plus additional resources and referrals to therapists. Common topics for coaching include anxiety, ADHD, bullying, depression, self-esteem, social media and technology addiction, among many others. To get started, visit **bendhealth.com/coaching** and create an account. Once you register, you will be connected with a coach in less than 48 hours.

UHC Enhanced Resources

LEVEL2 SPECIALTY CARE TYPE 2 DIABETES MANAGEMENT PROGRAM

Level2 is an evidence-based clinical program designed to help members lower glucose to improve type 2 diabetes. Members start with a no-cost continuous glucose monitor (CGM) to see their glucose in new ways. Members will also receive virtual access to a clinical care team, coaches, and a step-by-step method to build new habits and feel better. For more information and to get started, visit **mylevel2.com**.

ADVOCATE4ME ELITE

Below is an overview of Advocate4me Elite. You can access these services by calling the number on the back of your UHC ID card, through **myUHC.com** or through the UHC mobile app.

- Members have direct access to a designated team of behavioral Health Specialists.
- Access to highly trained Advocates that specialize in resolving complex claim issues and other complicated challenges, real time.
- Guidance and education about care choices that could help lower costs.
- Comprehensive support for members who have a child with complex medical needs, to help navigate the system and ease the burden on the family.
- Gender identity support.

REAL APPEAL

Real Appeal is an online weight loss program available to you and your eligible family members at no cost as part of your health plan benefits. Real Appeal offers:

- A **Transformation Coach** who leads online group sessions
- **Digital Tools** to track your food, activity and weight loss progress
- A **Success Kit** that includes scales, recipes and workout DVDs
- **Improved Health** and an even fuller and more active life!

ONE PASS SELECT

One Pass Select is a flexible fitness and wellness program designed to support your health goals—on your terms. With access to thousands of gyms, studios, and digital fitness options nationwide, you can choose the membership level that fits your lifestyle. There are no long-term commitments, and you can even add family members at a discount.

To enroll in One Pass Select, visit **member.uhc.com/coverage/additional**, sign in or register, then select the One Pass Select tile.

Maven & Fertility Solutions Plus

MAVEN

Maven is a digital health platform that provides support throughout your family-building journey, whether you're just thinking about starting a family or exploring your options.

The below resources are available to all US-based employees and covered dependents enrolled in a UHC medical plan:

Maternity and Newborn Care

- Holistic support through pregnancy, postpartum, and return to work
- Screenings, education for postpartum mental health, and enhanced support for high-risk members
- Access to coaching and childcare resources as parents return to work

Parenting & Pediatrics

- On-demand, 24/7/365 specialized parent coaching, pediatric care, special needs support
- Extensive library of personalized, digestible content

Menopause & Ongoing Care

- 24/7/365 virtual access to menopause specialists who can provide holistic and specialized care, clinically-approved education, mental health support, and trusted referrals
- Educational articles and live classes from providers who specialize in menopause and related symptoms

The below benefits are available to all US-benefits eligible employees. Enrollment in a GT UHC medical plan is not required.

Adoption and Surrogacy

- Book on-demand video appointments and message with providers spanning 35+ specialties, including adoption and surrogacy coaches
- Get expert navigation and referrals to top-rated fertility clinics and treatment options in your area
- Get adoption and surrogacy support, including guidance in selecting the right clinic or agency to grow your family
- Manage expenses through Maven Wallet, an easy-to-use digital tool that helps track reimbursable family-building costs

Medical Benefits

MONTHLY EMPLOYEE CONTRIBUTIONS

* You will pay the full medical premium for domestic partner coverage on a post-tax basis.
**The One Step Plan is not available to new enrollees.

Business Staff

	NETWORK PLAN	TIERED PLAN	ONE STEP PLAN**
Employee Only	$96.58	$96.58	$374.09
Employee + Spouse	$400.80	$400.80	$959.89
Employee + DP*	$1,068.52	$1,049.93	$1,419.42
Employee + Child(ren)	$297.74	$297.74	$789.08
Employee + Child(ren) + DP*	$1,269.65	$1,251.06	$1,834.37
Employee + Family	$657.33	$657.33	$1,487.95

Managers

	NETWORK PLAN	TIERED PLAN	ONE STEP PLAN**
Employee Only	$103.26	$103.26	$397.85
Employee + Spouse	$430.21	$430.21	$1,020.83
Employee + DP*	$1,075.20	$1,056.61	$1,443.18
Employee + Child(ren)	$319.59	$319.59	$839.18
Employee + Child(ren) + DP*	$1,291.50	$1,272.91	$1,884.47
Employee + Family	$705.56	$705.56	$1,582.41

Directors

	NETWORK PLAN	TIERED PLAN	ONE STEP PLAN**
Employee Only	$198.74	$198.74	$649.89
Employee + Spouse	$708.89	$708.89	$1,487.68
Employee + DP*	$1,170.68	$1,152.09	$1,695.22
Employee + Child(ren)	$520.27	$520.27	$1,201.99
Employee + Child(ren) + DP*	$1,492.18	$1,473.59	$2,247.28
Employee + Family	$1,107.64	$1,107.64	$2,242.78

Associate

	NETWORK PLAN	TIERED PLAN	ONE STEP PLAN**
Employee Only	$227.99	$227.99	$745.53
Employee + Spouse	$813.20	$813.20	$1,706.59
Employee + DP*	$1,199.93	$1,181.34	$1,790.86
Employee + Child(ren)	$596.83	$596.83	$1,378.85
Employee + Child(ren) + DP*	$1,568.74	$1,550.15	$2,424.14
Employee + Family	$1,270.62	$1,270.62	$2,471.52

Shareholders

	NETWORK PLAN	TIERED PLAN	ONE STEP PLAN**
Employee Only	$474.39	$474.39	$933.67
Employee + Spouse	$1,092.29	$1,092.29	$1,979.00
Employee + DP*	$1,446.33	$1,427.74	$1,979.00
Employee + Child(ren)	$915.53	$915.53	$1,730.11
Employee + Child(ren) + DP*	$1,887.44	$1,868.85	$2,775.40
Employee + Family	$1,770.63	$1,770.63	$2,775.41

Medical Benefits

SPOUSE ATTESTATION

You can enroll your spouse under a GT medical plan, but you must attest to whether they're eligible for coverage under their own employer's plan. If your spouse is eligible for another employer plan, you must pay an additional $100 per month for your GT medical benefits. This attestation does not apply if your spouse is self-employed, has an individual insurance policy unrelated to employment, or is enrolled in Medicaid or Medicare. This attestation does not apply if you're enrolling your domestic partner.

TOBACCO USE ATTESTATION

If you or your enrolled spouse attest to being a tobacco user, you and/or your spouse must complete a tobacco cessation program within 120 days of your date of hire/benefits eligibility to avoid paying an additional $100 contribution per month, per tobacco user for GT medical benefits. This requirement does not apply to dependent children or a domestic partner, regardless of their tobacco-use status.

If You Use Tobacco Products and Are Ready to Quit

You can access UHC's free Quit for Life® Tobacco Cessation Program. If preferred, you can use another tobacco cessation program (such as one recommended by your doctor).

If you or your enrolled spouse is a tobacco user and you think you might be unable to complete a tobacco cessation program due to medical reasons, you ***may*** qualify to avoid paying the surcharge. Contact hrbenadmin@gtlaw.com and we will work with you, and your doctor, to find another program for you.

Confidentiality: Your attestations are collected by the GT medical plan solely for the purpose of determining your contribution level. GT medical plans and its vendors are subject to HIPAA's privacy and security rules, which protect your information.

DOMESTIC PARTNER COVERAGE

You will pay the full medical premium for domestic partner coverage on a post-tax basis.

Dental Benefits

Cigna

GT offers three dental plan options through Cigna. Understanding the differences between them can help you choose the coverage that best meets your needs.

PLAN	PLAN FEATURES
Dental Maintenance Organization (DHMO) Plan*	• Provides benefits only if you see an in-network dentist (smaller network) • Requires you to choose a primary care dentist to coordinate all of your care • Provides benefits based on a copay schedule
Dental Preferred Provider Organization (DPPO) Plan	• Allows you to receive care from a dentist in the network or outside the network • Pays a portion of your expenses after you meet your annual deductible, except for preventive care which is covered at 100% • The annual maximum will increase by $100 for members who had preventive dental care through the GT dental plan in 2025. See chart on next page for details.

OUT-OF-NETWORK COVERAGE

Benefits will be paid differently when opting to use an out-of-network dentist. Each plan has its unique determination on how the benefits will be paid. Keep in mind there are no out-of-network benefits for the Cigna DHMO.

TOTAL DPPO 1 – Maximum Allowable Charge

The Allowed Amount for Non-Participating Providers will be based on the rate Cigna has negotiated with Participating Providers in the area. Note that a Maximum Allowable Charge for an out-of-network provider in the DPPO1 plan may be lower than a Maximum Reimbursable Charge for an out-of-network provider in the DPPO2 plan.

TOTAL DPPO 2 – Maximum Reimbursable Charge (Also referred to as U&C, R&C and UCR)

The maximum reimbursable charge is most Cigna will pay a dentist for a covered service or procedure for out-of-network dental care. Normally applies as a percentile, based on the published prevailing Health Care charges designated by zip code data.

How to Find a Provider

To search for a dentist, visit Cigna.com and click "Find a Doctor, Dentist or Facility." Follow the prompts and when asked to choose your plan, select:

- **Access Plus DHMO:** CIGNA DENTAL CARE DHMO > Cigna Dental Care Access Plus
- **Total DPPO 1 or Total DPPO 2:** DPPO/EPO > Total Cigna DPPO

You may select a Network Pediatric Dentist for your child under the age of 13 by calling Customer Service at **1.800.Cigna24** to get a list of Network Pediatric Dentists in your area.

*__Minnesota Residents:__ When enrolling in a Cigna Dental Care® plan, you must visit your selected network dentist in order for the charges on the Patient Charge Schedule to apply. You may also visit other dentists that participate in our network, or you may visit dentists outside the Cigna Dental Care® network. If you do, the fees listed on the Patient Charge Schedule will not apply. You will be responsible for the dentist's usual fee. We will pay 50% of the value of your network benefit for those services. You'll pay less if you visit your selected Cigna Dental Care® network dentist. Call customer service for more information.

Dental Benefits

Cigna

Below is an overview of the benefits.

BENEFITS	ACCESS PLUS DHMO*	TOTAL DPPO 1**		TOTAL DPPO 2**	
	In-Network Only	In-Network	Out-of-Network***	In-Network	Out-of-Network***
Calendar Year Deductible (Ded.) Individual / Family	N/A	$100 / $300	$100 / $300	$50 / $150	$50 / $150
Annual Maximum (per person)	None	Year 1: $1,000, Year 2: $1,100, Year 3: $1,200, Year 4+: $1,300****		Year 1: $2,500, Year 2: $2,600, Year 3: $2,700, Year 4+: $2,800****	
Preventive Services	Copay schedule	100%, ded. waived	100%, ded. waived	100%, ded. waived	100%, ded. waived
Basic Services		80%	80%	80%	80%
Major Services		50%	50%	50%	50%
Orthodontia (child and adult)	$2,400 copay, limitations apply	50%		50%	
Orthodontia Lifetime Maximum	None	$1,000		$2,500	

* DHMO is NOT available in **AK, ME, MO, NH, NM, ND, SD, VT, WY.**
** DPPO Plan names in Texas are known as Dental Choice 1 and Dental Choice 2.
*** All out-of-network dental services, including preventive care, may result in balance billing, meaning you can be billed for the difference between the provider's charge and the plan's allowed amount. For details on allowed amounts under the dental PPO plans, refer to the Out-of-Network Coverage section on the previous page.
**** Increase contingent upon receiving Preventive Services in the previous plan year.

MONTHLY CONTRIBUTIONS

	ACCESS PLUS DHMO	TOTAL DPPO 1	TOTAL DPPO 2
Employee Only	$16.79	$42.19	$73.68
Employee + Spouse	$30.38	$83.12	$145.16
Employee + Child(ren)	$35.69	$96.79	$169.03
Family	$54.96	$134.99	$252.34

Cigna DPPO Preventive Care Wellness Plus Benefit

For members who have had preventive dental care through the GT dental plan in 2025, the annual maximum will increase by $100 for 2026. Members can confirm this by visiting **mycigna.com**, or by calling Cigna customer service at **800-997-1654** (group #3344563).

Vision Benefits

UnitedHealthcare (UHC)

The vision plan helps you save money on annual eye exams, glasses and contact lenses.

The plan pays benefits for both in-network and out-of-network services; however, you'll receive maximum value from your vision benefits when you choose network providers. If you see a network provider, you'll pay a copay for most services. If you receive care outside the network, you must pay the full cost and file a claim to be reimbursed for a portion of your costs.

Below is an overview of the benefits.

	VISION PLAN	
BENEFIT	In-Network	Out-of-Network Reimbursement Amount
Exam *(Every calendar year)*	$10 copay	Up to $40
Lenses *(Every calendar year)* Single / Bifocal / Trifocal	$25 copay	Up to $40 / Up to $60 / Up to $80
Frames *(Every calendar year)*	$150 allowance; 30% off of amounts over $150	Up to $45
Contacts – In lieu of frames *(Every calendar year)*	Conventional: Select Lenses: $25 copay, up to 4 boxes Non-Select Lenses: up to $125 allowance Medically Necessary: Covered in full	Conventional: Up to $125 Medically Necessary: Up to $210

Additional Vision Benefits include:

- **Laser Vision Discount:** Save up to 35% off the national average price of LASIK.
- **Blue Light Protection Discount:** Savings from retail pricing on blue-light filters for devices.
- **Children's and Maternity Eye Care Replacement Eyeglasses:** Members ages 0-18 and members pregnant or breastfeeding who have a prescription change of 0.5 diopter or more are eligible for a replacement frame and lenses. The replacement benefits are the same as the benefits for the initial frame and lenses.

MONTHLY CONTRIBUTIONS

Employee Only	$6.05
Employee + Spouse	$11.46
Employee + Child(ren)	$13.46
Family	$18.92

How to Find a Provider

UHC has more than 53,000 retail and independent in-network providers that are thoroughly screened and meet the highest standards of care. To find an in-network vision care provider near you, go to **www.myuhcvision.com** and use the Provider Quick Search tool. You can also call **800-638-3120** to speak to a customer service representative.

Health Savings Account (HSA)

Optum Bank

Employees who enroll in the HSA for the first time will receive a debit card from Optum Bank to pay for eligible expenses.

Participants enrolled in the **Tiered Plan** or **One Step Plan** may open a tax-advantaged HSA through Optum Bank. This account helps you save money from your paycheck for eligible health care expenses. Because money is saved before taxes, you save money on what you would have paid in taxes.

You can use this account to cover qualified medical, dental and vision costs, such as copays, deductibles and prescriptions. Visit optumbank.com or call 866-234-8913 for a full list of qualifying expenses and eligibility rules.

Eligibility Requirements

- Must be enrolled in the Tiered or One Step medical plan
- Must not be enrolled in Medicare
- Must not be covered by other medical insurance
- Must not have received VA medical benefits at any time in the past three months
- Spouse not contributing to/participating in a general-purpose FSA
- Consult a tax advisor for additional restrictions

Key Advantages

- **It's flexible:** Use your HSA now, or save it for later. You decide when to save and when to spend. You can even save for health care expenses after you retire.
- **No "use it or lose it" rule:** The money in your HSA belongs to you. It rolls over each year and you can take it with you if you leave the firm.
- **It's triple tax-advantaged (applies to federal and most state taxes):***
  - Pay no taxes on money you contribute.
  - Pay no taxes on interest you earn on investments.
  - Pay no taxes when you withdraw money to pay for eligible healthcare expenses.

  * Federal tax savings regardless of your state of residence. State tax savings not available in every state (i.e. CA, NJ). Consult a tax professional for tax-related questions.
- **Invest your account:** Once your account balance reaches $2,000, you can choose to invest it in a variety of mutual fund investments.

ANNUAL MAXIMUMS

Each year, the IRS sets a maximum contribution amount. In 2026, the total in your account cannot exceed:

- **Individual:** $4,400
- **Family:** $8,750
- **Catch-Up Contribution:** If you are (or will be) 55 or older in 2026, you can contribute an additional $1,000 to your HSA, beyond the standard IRS contribution limits.

Flexible Spending Accounts (FSAs)

HealthEquity/Wageworks

Flexible Spending Accounts (FSAs) allow you to contribute pre-tax dollars from your paycheck for qualified out-of-pocket healthcare expenses. You decide at enrollment how much you want to save (up to the annual contribution limits). Throughout the year, you make contributions through pre-tax payroll deductions in equal amounts.

You may not change contributions or cancel within the calendar year, unless you have an eligible IRS-qualifying family status change.

You must re-elect your FSA contribution amount every year. Your previous election will not carry over to the new plan year.

	STANDARD HEALTH CARE FSA	LIMITED PURPOSE HEALTH CARE FSA	DEPENDENT CARE FSA
Who is allowed to enroll?	Available to members of the Network Plan, as well as Tiered and One Step plan members who do not contribute to the HSA. Eligible employees not enrolled in a GT medical plan can also enroll.	Available to Tiered and One Step plan members who contribute to the HSA	All eligible GT employees
What is the account used for?	Medical, dental, and vision expenses, such as deductibles, coinsurance, copays, glasses and contact lenses, orthodontia and other dental expenses	Dental and vision expenses only, until your medical plan deductible has been reached. Contact the HR Benefits theam after your deductible has been reached for more information	Dependent care expenses such as day care and after school programs for children under age 13, or elder care expenses, so you and your spouse can work or attend school full time
What is the contribution limit?	$3,400	$3,400	$7,500, or $3,750 if married and filing separate tax returns
How do you pay for expenses?	Debit Card	Debit Card	Reimbursement
Does money rollover year-to-year?	Yes, you can roll over up to $680 unused funds. All other money in excess of $680 will be forfeited	Yes, you can roll over up to $680 unused funds. All other money in excess of $680 will be forfeited	No, any money left in the account after the plan year will be forfeited

Visit www.wageworks.com or call 877-924-3967 for a full list of qualifying expenses and eligibility rules.

Voluntary Benefits

Sun Life

SUN LIFE BENEFITS EXPLORER

Visit the **Sun Life Benefits Explorer** created just for GT. You may also find the link in the Benefits Brochure (under Voluntary Benefits) or scan the QR code you see here. You'll find in-depth benefits information, helpful videos and FAQs to help you decide if GT's voluntary offerings will help you create a comprehensive suite of valuable benefits for you and your family.

Visit **Sun Life Benefits Explorer** or call **800-247-6875** for more information.

BASIC LIFE INSURANCE

GT provides all eligible employees with a life insurance benefit. While you are automatically enrolled in this benefit, it is important to periodically review who you have listed as your beneficiary and make updates as needed.

OPTIONAL LIFE INSURANCE

You have the option to supplement your firm-paid coverage by purchasing additional life insurance for yourself, your spouse and your children. You are required to purchase coverage for yourself in order to enroll your eligible family members.

- Employees can elect up to $1,450,000 in increments of $10,000
- Spouse/Domestic Partner coverage can be purchased in increments of $5,000, up to $250,000
- Child coverage can be purchased in increments of $5,000, up to $50,000

Evidence of Insurability (EOI)

EOI, or proof of good health, is required if:

- You decline coverage during your initial eligibility period and enroll at a later date.
- You apply for insurance in excess of the guaranteed issue amount.
- You increase your existing coverage by more than $30,000 or above the guaranteed issue amount ($500,000 for all employees).

Sun Life Financial will notify you if you need to submit an EOI. If an EOI is required, Sun Life Financial may arrange for you to take a medical exam (at the insurance company's expense) and/or complete a medical questionnaire.

IMPORTANT: If you're required to complete an EOI, coverage will not go into effect and payroll deductions for the benefit amount requiring EOI will not begin until Sun Life Financial approves the application.

Basic and Optional Life insurance policies may be portable if you leave the firm. Guidelines may apply.

Voluntary Benefits

Sun Life

Voluntary Life Insurance Coverage Cost

You pay for this coverage through per-pay period post-tax payroll deductions. Employee rates are determined by your age and tobacco status. Spouse/Domestic Partner rates are determined by the employee's age and the Spouse/Domestic Partner's tobacco status.

To determine your monthly cost, take the requested amount and divide it by 1,000. Then, multiply that number by the rate. For example: $120,000 / 1,000 x $.063 = $7.56

AGE	OPTIONAL LIFE (NON-SMOKER)	OPTIONAL LIFE (SMOKER)
0-19	0.039	0.047
20-24	0.039	0.047
25-29	0.039	0.047
30-34	0.063	0.063
35-39	0.070	0.078
40-44	0.078	0.125
45-49	0.117	0.219
50-54	0.196	0.353
55-59	0.352	0.610
60-64	0.540	0.845
65-69	0.993	1.236
70-74	1.697	2.307
75+	2.925	4.121

Voluntary Life Insurance Child Rate

AGE	RATE
0-26	0.130

Basic and Optional Life insurance policies may be portable if you leave the firm. Guidelines may apply.

Voluntary Benefits

Sun Life

VOLUNTARY ACCIDENT INSURANCE

Voluntary accident insurance through Sun Life helps cover the cost of care and other unexpected expenses if you're injured, lose your hearing or vision or pass away.

Visit **Sun Life Benefits Explorer** to review plan details and download the plan summary or call **800-247-6875** for more information.

Eligibility	Full-time employees working at least 30 hours per week in the U.S.
Covered Conditions	Fractured bones, burns, dislocations and more; exclusions may apply
Benefit Amount	Benefits are paid directly to you with no health questions asked; Refer to the schedule of benefits on the Sun Life Benefits Explorer site for more details
Wellness Benefit	$100 when a covered test is performed (1 per year per covered member)
Eligible Expenses	You choose how to use your benefit – housekeeping services, mortgage, car payments, etc.

VOLUNTARY ACCIDENT INSURANCE RATES

You pay for this coverage through monthly post-tax payroll deductions.

COVERAGE FOR	OPTION 1	OPTION 2
Employee Only	$7.44	$11.75
Employee and Spouse / Domestic Partner	$12.62	$20.64
Employee and Children	$14.12	$23.57
Employee and Children + Domestic Partner	$19.30	$32.46
Employee and Family	$19.30	$32.46

Voluntary Benefits

Sun Life

VOLUNTARY HOSPITAL INDEMNITY INSURANCE

Voluntary hospital indemnity insurance through Sun Life helps to cover the costs of out-of-pocket medical costs incurred with a covered hospital stay. There are two plan coverage levels available: the Low Plan and the High Plan.

Visit **Sun Life Benefits Explorer** to review plan details and download the plan summary or call **800-247-6875** for more information.

Eligibility	Full-time employees working at least 30 hours per week in the U.S.
Covered Conditions	Hospital confinements due to covered accident and sickness, mental and nervous disorders, substance abuse, routine pregnancy, and newborn routine care; exclusions may apply
Benefit Amount	Benefits are paid directly to you with no health questions asked; Refer to the schedule of benefits on the Sun Life Benefits Explorer site for more details
Wellness Benefit	$100 when a covered test is performed (1 per year per covered member)
Eligible Expenses	You choose how to use your benefit – housekeeping services, mortgage, car payments, etc.

VOLUNTARY HOSPITAL INDEMNITY INSURANCE RATES

You pay for this coverage through monthly post-tax payroll deductions.

COVERAGE FOR	OPTION 1	OPTION 2
Employee Only	$12.96	$22.84
Employee and Spouse / Domestic Partner	$27.21	$48.25
Employee and Children	$21.50	$37.75
Employee and Children + Domestic Partner	$35.75	$63.16
Employee and Family	$35.75	$63.16

Voluntary Benefits

Sun Life

VOLUNTARY CRITICAL ILLNESS INSURANCE

Voluntary critical illness insurance provides a fixed benefit amount after a serious illness or condition, such as a heart attack, stroke or cancer.

Visit **Sun Life Benefits Explorer** to review plan details and download the plan summary or call **800-247-6875** for more information.

Eligibility	You and your spouse / domestic partner
Covered Conditions	Certain illnesses, such as heart attack, stroke or cancer; exclusions may apply
Benefit Amount	• Employees are eligible to receive a lump sum benefit equal to $5,000, $15,000 or $25,000 • Spouse coverage equals half the amount of employee coverage (if you purchase $5,000 for yourself, you must purchase $5,000 for your spouse/domestic partner)
Wellness Benefit	$100 when a covered test is performed (1 per year per covered member)
Eligible Expenses	You choose how to use your benefit – housekeeping services, mortgage, car payments, etc.

CRITICAL ILLNESS INSURANCE RATES

You pay for this benefit through post-tax payroll deductions. Coverage rates are determined by your and your spouse or domestic partners age and tobacco use.

To determine your monthly cost, take the requested amount and divide it by 1,000. Then, multiply that number by the rate. **For example: $15,000 / 1,000 x $.87 = $13.05**

AGE	CRITICAL ILLNESS / CANCER (NON-SMOKER)	CRITICAL ILLNESS / CANCER (SMOKER)
0-19	0.630	0.640
20-24	0.630	0.640
25-29	0.630	0.640
30-34	0.870	0.980
35-39	0.870	0.980
40-44	1.590	2.210
45-49	1.590	2.210

AGE	CRITICAL ILLNESS / CANCER (NON-SMOKER)	CRITICAL ILLNESS / CANCER (SMOKER)
50-54	3.060	5.370
55-59	3.060	5.370
60-64	5.980	12.400
65-69	5.980	12.400
70-74	9.550	19.740
75-79	12.510	23.370
80+	14.170	25.170

Disability Benefits

SHORT- AND LONG-TERM DISABILITY

Disability benefits help protect your earnings in the event you are ill or injured and unable to work for a short or extended period of time. GT pays the cost of short-term disability (STD) and long-term disability (LTD) coverage for eligible employees.

	STD	LTD
Eligible Employees	Eligible US Professional Staff working at least 30 hours per week, unless required by law	All eligible employees
Benefits Begin	After 7 continuous days	After 90 days
Maximum Benefit	70% of your weekly earnings (up to $2,500)	Percentage of your monthly earnings
Benefit Duration	Up to 12 weeks (or 8 weeks for maternity)	Until you reach Social Security Normal Retirement Age or are no longer disabled
Tax Implications	Since GT pays for this benefit, any benefit you receive will be taxable	You may elect to have premiums taxed during enrollment (therefore, any benefits you receive will not be taxed)

Additional Benefits

Assist America

IDENTITY FRAUD PROTECTION

You can keep your identity and credit history secure with Assist America's identity fraud protection. With proactive tools like credit card/document protection and internet fraud monitoring, this benefit can help keep your important information safe.

To register your credit cards for fraud surveillance and store your information in one central location, go to https://www.assistamerica.com/Other-Services/Identity-Protection/Sun-Life-Id-Protection.aspx or call 877-409-9597.

- Access code: **18327**
- Membership number: 01-AA-SUL-100101

If you become a victim of identity theft, call 877-409-9597 anytime.

TRAVEL ASSISTANCE

If you're traveling more than 100 miles from home, Assist America provides valuable emergency services, including:

- Contact with a medical professional
- Hospital admission
- Medical evacuation
- And more

Review the highlights of the program, and to sign up, enter the reference number on the Assist America member login page. You can also download the mobile app.

Call 800-872-1414 inside the U.S., 609-986-1234 outside the U.S. email medservices@assistamerica.com or download the app from the App Store or Google Play to access this program. Use reference number **01-AA-SUL-100101**.

Additional Benefits

MILK STORK

Milk Stork provides breast milk shipping services for mothers traveling on Firm business. Register and get more information at **https://www.milkstork.com/gtlaw.**

PET INSURANCE

MetLife Pet Insurance provides coverage for dogs, cats and many exotics (in certain states) to help reimburse you for covered vet visits, accidents, illness and more. You can also keep your pet safe and healthy with optional preventive care coverage.

With MetLife, you have the power of choice to customize your pet insurance for your pet's unique needs and help protect their health and well-being, with:

- Flexible insurance plans that can cover the entire pet family with no breed exclusions:
  - Levels of coverage from $500 to unlimited
  - $0-$2,500 deductible options
  - Reimbursement percentages from 50%-90%
- Freedom to visit any U.S. veterinarian
- Family plans covering multiple cats and dogs on one policy
- 24/7 access to Telehealth Concierge Services for immediate assistance
- Discounts up to 30% and additional offers on pet care, where available
- Optional Preventive Care coverage
- Coverage of previously covered pre-existing conditions when switching from other pet insurance providers/carriers

Rates vary based on plan type, pet species and your state of residence. Visit **www.metlife.com/getpetquote** for a quote and to enroll for coverage. For questions, please contact MetLife Pet Insurance at **800-438-6388**.

If you have questions regarding a current or former Nationwide Pet Insurance policy, contact Nationwide's Customer Care team at **800-540-2016**.

Employee Assistance Program

Optum

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The **confidential, no-cost** EAP is available to all employees and their household family members 24/7 for counseling and referral services. Enrollment in a GT medical plan is not required to access EAP resources. The Optum EAP can help with:

- Finding care for a loved one
- Depression, stress and anxiety
- Child care, such as choosing daycare and summer camps
- Legal concerns
- Financial issues
- Pet care services
- And much more

You each get up to **five no-cost** counseling visits per incident, per year (via video chat or face to face) and unlimited support via telephone. You also have unlimited access to educational tools and resources, such as self-help guides and podcasts.

Call 866-248-4096 or visit liveandworkwell.com **(password: Greenberg)** to get started. You can also download the Optum Assist mobile app for audio tracks, articles and digital booklets.

TALKSPACE

Talkspace is an online therapy platform that makes it easy and convenient for you to access a licensed behavioral therapist from anywhere, at any time. With Talkspace, you can send private messages to, or hold live video sessions with, your dedicated therapist through a secure digital app platform.

How Talkspace Works

Tell Talkspace what you're looking for, and get matched with 3 potential therapists based on your preferences. Once you select your ideal match, you can begin therapy the very same day. Once you engage with your therapist, you will be able to send unlimited text, video & voice messages to you therapist, whenever works best for you.

When you get pre-approval through the EAP, you have access to 5 free sessions. If you exhaust the benefit, you have the ability to continue using Talkspace therapists through your UHC medical benefits.

CALM APP

You have access to the Calm app for free through your Optum EAP. Calm can help you tackle stress, get a good night's sleep, and feel more present in your life. With the convenience of an app, you can use Calm whenever it fits your schedule to work on whatever is most important to you.

Visit liveandworkwell.com **(password: Greenberg)** to get started.

Already have the Calm app? Open the app, go to **Profile > Settings > Link Organization Subscription**. Enter organization Code **Optum EWS** and in the group code field, enter **Greenberg**

Important Contacts

Scan for easy access!

IMPORTANT CONTACTS

My Smart Contacts provides contact information for benefit carriers. You will have convenient access to carrier contact information and high level details on plan coverage. Visit www.mysmartcontacts.com/mygtlaw today and add to your home screen for easy access!

BENEFIT	VENDOR	GROUP NUMBERS	PHONE	WEBSITE / EMAIL
Employee Assistance Program	Optum	Password: Greenberg	866-248-4096	www.liveandworkwell.com Password: Greenberg
Medical	UnitedHealthcare (UHC)	711014	833-312-1227	www.myuhc.com
Virtual Visits	UnitedHealthcare (UHC)	N/A	N/A	www.myuhc.com
Prescriptions	Capital Rx	Rx Bin: 610852 Rx PCN: CHM Rx Group: JD363	833-202-5166	www.cap-rx.com
Health Savings Account	Optum Bank	711014	866-234-8913	www.optumbank.com
Flexible Spending Account	Health Equity / Wage Works		877-924-3967	www.wageworks.com www.healthequity.com
Benefits Direct Billing for Employees on Leave of Absence	Health Equity		877-722-2667	www.healthequity.com
Dental	Cigna	3344563	800-997-1654	www.mycigna.com
Vision	UnitedHealthcare (UHC)	711014	866-734-7670	www.myuhc.com
Life Insurance & Disability	Sun Life Financial	11667	800-247-6875	www.sunlife.com
FMLA / Leave of Absence	Sun Life Absence Management Services		877-786-3652	N/A
Critical Illness, Hospital and Accident Insurance	Sun Life Financial	934318	800-247-6875	www.sunlife.com
Pet Insurance	MetLife		800-438-6388	www.metlife.com/getpetquote
Travel Assistance and Identity Theft	Assist America	01-AA-SUL-100101	877-409-9597	www.securassist.com/sunlife Access code: 18327

App-solutely Essential

Access all GT carrier phone numbers, websites and apps at **www.mysmartcontacts.com/mygtlaw**

BENEFIT	VENDOR	APP
Employee Assistance Program	Optum	
Talkspace	Talkspace	
Sleep, Meditation, Relaxation	Calm	
Personalized Mental Health Resources	Calm Health	
Medical, Virtual Visits and Vision	UnitedHealthcare (UHC)	
Prescriptions	Capital Rx	
Health Savings Account	Optum Bank	
Flexible Spending Account	Health Equity / Wage Works	
Dental	Cigna	
Travel Assistance and Identity Theft	Assist America	
Basic and Optional Life Insurance, Accident Insurance, Critical Illness Insurance	Sun Life Benefits Explorer	

Notices

MEDICARE NOTICE OF CREDITABLE COVERAGE

All notices can be found on **gtworkday.gtlaw.com.**

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Notice of Creditable Coverage

This Notice applies only if you and/or your dependent(s) are enrolled in a Greenberg Traurig P.A. medical plan and you are eligible for Medicare. If this does not apply to you, you may ignore this notice.

Please read this notice carefully and keep it where you can find it. This notice has information about your prescription drug coverage with Greenberg Traurig P.A. and your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your employer coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Greenberg Traurig has determined that the prescription drug coverage offered under the Greenberg Traurig plan(s) are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Greenberg Traurig Coverage If You Decide to Join A Medicare Drug Plan?

Your health plan coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents may not be eligible to receive all of your current health and prescription drug benefits. If you do decide to join a Medicare drug plan and drop your employer coverage, be aware that you and your dependents may not be eligible to receive health and prescription drug benefits in the future.

Notices

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

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

For More Information About This Notice Or Your Greenberg Traurig Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For More Information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

October 10, 2025
Greenberg Traurig
Rhonda Herman
Director of Benefits
401 East Las Olas Boulevard Suite 2000
Fort Lauderdale, FL 33301
954-468-1762

Notices

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If an eligible employee declines enrollment in a group health plan for the employee or the employee's spouse or dependents because of other health insurance or group health plan coverage, the eligible employee may be able to enroll him/herself and eligible dependents in this plan if eligibility is lost for the other coverage (or because the employer stops contributing toward this other coverage). However, the eligible employee must request enrollment within 30 days after the other coverage ends (or after the employer ceases contributions for the coverage).

In addition, if an eligible employee acquires a new dependent as a result of marriage, birth, adoption or placement for adoption, the eligible employee may be able to enroll him/herself and any eligible dependents, provided that the eligible employee requests enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Furthermore, eligible employees and their eligible dependents who are eligible for coverage but not enrolled, shall be eligible to enroll for coverage within 60 days after becoming ineligible for coverage under a Medicaid or Children's Health Insurance Plan (CHIP) plan or being determined to be eligible for financial assistance under a Medicaid, CHIP, or state plan with respect to coverage under the plan.

To request special enrollment or obtain more information, contact your health plan.

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 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, contact your health plan.

Notices

NOTICE OF HIPAA PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of the Greenberg Traurig P.A. Health Plan (the "Plan") sponsored by Greenberg Traurig P.A. ("Plan Sponsor") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health

Act (HITECH Act) and subsequent amending regulations ("HIPAA Privacy Rule"). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. We are required to provide this HIPAA Privacy Notice to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

- Your past, present, or future physical or mental health or condition;
- The provision of health care to you; or
- The past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact the individual listed at the end of this notice.

Our Responsibilities

Greenberg Traurig P.A. is required by law to:

- Maintain the privacy of your protected health information;
- Provide you with certain rights with respect to your protected health information;
- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your Protected health information; and
- Follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised HIPAA Privacy Notice electronically or by first class mail to the last known address on file.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

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For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. We may share or discuss your PHI with your family members or others involved in your care or payment for your care, unless you object in writing and provide the objection to the Plan's HIPAA contact listed at the end of this Notice. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments. In any of these cases, we will disclose only the information necessary to resolve the issue at hand.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

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Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Notices

Law Enforcement. We may disclose your protected health information if asked to do so by a law-enforcement official:

- in response to a court order, subpoena, warrant, summons, or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your protected health information to the correctional institution or law-enforcement official if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when:

- the individual identifiers have been removed; or
- when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or
- treating such person as your personal representative could endanger you; and
- in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your protected health information, you must submit your request in writing to the individual listed at the end of this Notice. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the individual listed at the end of this Notice.

Notices

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the individual listed at the end of this Notice. You must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit it in writing to the individual listed at the end of this Notice. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person. To request restrictions, you must send your request in writing the individual listed at the end of this notice.

In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply-for example, disclosures to your spouse.

Notices

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing the individual listed at the end of this notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact to the individual listed below. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

HIPAA Contact

Lisa Richter
Director of Talent Services Programs and Policies
500 Campus Drive, Suite 400
Florham Park, NJ 07932-0677
973-360-7900

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 **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 –

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

OMB Control Number 1210-0137 (expires 1/31/2026)

ALABAMA – Medicaid
http://myalhipp.com | 1-855-692-5447

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

ARKANSAS – Medicaid
http://myarhipp.com | 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp | 1-916-445-8322 | Fax: 1-916-440-5676
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
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
1-877-357-3268

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

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid
Website: https://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: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
1-800-338-8366
Hawki: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki | 1-800-257-8563
HIPP: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp | 1-888-346-9562

KANSAS – Medicaid
https://www.kancare.ks.gov | 1-800-792-4884
HIPP: 1-800-967-4660

Notices

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

LOUISIANA – Medicaid
www.medicaid.la.gov
www.ldh.la.gov/lahipp
1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

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

MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa
1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
https://mn.gov/dhs/health-care-coverage/ | 1-800-657-3672

MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
1-573-751-2005

MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
1-800-694-3084 | HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov
1-855-632-7633 | Lincoln: 1-402-473-7000 |
Omaha: 1-402-595-1178

NEVADA – Medicaid
http://dhcfp.nv.gov | 1-800-992-0900

NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov | 1-603-271-5218
HIPP program toll free: 1-800-852-3345, ext 15218

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

NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid
1-800-541-2831

NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov | 1-919-855-4100

NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare
1-844-854-4825

OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org | 1-888-365-3742

OREGON – Medicaid and CHIP
http://healthcare.oregon.gov/Pages/index.aspx | 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
1-800-692-7462
CHIP: https://www.pa.gov/agencies/dhs/resources/chip
1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov
1-855-697-4347, or 1-401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
https://www.scdhhs.gov | 1-888-549-0820

SOUTH DAKOTA - Medicaid
http://dss.sd.gov | 1-888-828-0059

TEXAS – Medicaid
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
1-800-440-0493

UTAH - Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP)
https://medicaid.utah.gov/upp/ | upp@utah.gov | 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
https://dvha.vermont.gov/members/medicaid/hipp-program
1-800-250-8427

VIRGINIA – Medicaid and CHIP
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: 1-800-432-5924

WASHINGTON – Medicaid
https://www.hca.wa.gov | 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
https://dhhr.wv.gov/bms | http://mywvhipp.com
Medicaid: 1-304-558-1700
CHIP Toll-free: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
1-800-362-3002

WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility
1-800-251-1269


GT GreenbergTraurig