FBT Gibbons

2026 Benefits Guide

Plan year: June 1 – December 31, 2026

Welcome to FBT Gibbons!

Inside This Guide

Questions?

If you have questions about your benefits, please contact FBT Gibbons Benefits or the Conner Strong & Buckelew Benefits Member Advocacy Center (Benefits MAC) at **800.563.9929** (Monday through Friday, 8:30 am to 5 pm ET) or go to **connerstrong.com/memberadvocacy** and complete the fields.

Benefits and Eligibility Overview

New Hire Eligibility

New hires become eligible for benefits the first of the month following or coinciding with your date of hire*. New hires must enroll in benefits within 30 days of hire or wait until the next open enrollment period to enroll.

FBT Gibbons will contribute toward your medical/prescription drug plan choice. Employees will pay the difference in premium for their election via payroll deductions. Any additional benefits elected are 100% employee paid.

* Exception: New hires become eligible for Sun Life benefits one month from their date of hire.

Medical Benefits

FBT Gibbons offers four medical plans administered by Horizon Blue Cross Blue Shield:

- EPO Plan
- OMNIA Plan
- High Deductible Health Plan
  - This plan can be paired with a Health Savings Account (HSA)
- Direct Access Plan

Dental Benefits

FBT Gibbons offers three dental plans administered by Horizon Blue Cross Blue Shield:

- Dental Choice Plan H
- Dental Option Plan
- Dental Option Plus Plan

Pre-Tax Spending Account Benefits

FBT Gibbons offers various pre-tax spending account benefits:

- Health Savings Account (Only available to those enrolled in a High Deductible Health Plan)
- Flexible Spending Account (FSA)
- Limited Purpose Flexible Spending Account (LPFSA)
- Dependent Care Flexible Savings Account (DCFSA)
- Mass Transit/Qualified Parking

Voluntary Benefits

FBT Gibbons offers multiple voluntary benefits to our benefit eligible employees including:

- Sun Life
  - Accident
  - Critical Illness
  - Hospital Indemnity
  - Optional Life and AD&D
- Healthiest You: Telemedicine
- Vision Service Plan
  - VSP Signature Plan
  - VSP Enhanced Plan
- Nationwide: Pet Insurance

Who is eligible to elect benefits?

If you are a FBT Gibbons full-time employee (working 30 or more hours per week), you are eligible to enroll in the benefits described in this Guide. Please remember that only eligible dependents can be enrolled.

Eligible dependents include your:

- Spouse
- Civil Union or Domestic Partner
- Dependent Child(ren)
  - Coverage will end at the end of the calendar year in which your child turns 26

How to Enroll

How Do I Enroll in Benefits?

If you wish to enroll in or waive any benefit plans offered, please contact FBT Gibbons Benefits.

Please Note: If you are enrolling a dependent, please be sure the dependent meets the FBT Gibbons benefit eligibility criteria and provide supporting documentation to FBT Gibbons Benefits within 30 days.

What Do You Need to Do Now?

- Review this Guide and discuss with your family members, if applicable.
- If you have any questions regarding the benefits outlined in this guide, contact FBT Gibbons Benefits or the Benefits Member Advocacy Center (Benefits MAC) by calling **800.563.9929**, via email at **cssteam@connerstrong.com** or via the web at **connerstrong.com/memberadvocacy**.

How Often Can I Change Plan Elections?

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next Open Enrollment period.

Qualified changes in status include: marriage, divorce, legal separation, civil union/domestic partnership status change, birth or adoption of a child, change in child's dependent status, death of a spouse, child or other qualified dependent, change in residence due to an employment transfer for you or your spouse/civil union/domestic partner, commencement or termination or adoption proceedings, or change in spouse's/civil union/domestic partner's employment status.

Qualified changes in status must be reported to FBT Gibbons Benefits within 30 days of experiencing the qualified change in status event. Employees are required to supply proof of the qualified change in status within 30 days of the event. According to IRS regulations, employees cannot change plans that are deducted on a pre-tax basis (including medical and dental insurance) until the next Open Enrollment, or if you experience a qualified change in status.

Medical & Prescription Employee Contributions

Below are the **MONTHLY** employee contributions that apply to your medical/prescription drug plans.

Medical/Prescription Plan Contributions

Plan	Coverage Tier	2026 Employee Contributions
EPO	**Single**	$343.57
	Two Adults	$921.40
	Employee/Child(ren)	$646.43
	Family	$1,270.30
OMNIA	**Single**	$449.83
	Two Adults	$1,177.98
	Employee/Child(ren)	$834.57
	Family	$1,615.31
HDHP HSA	**Single**	$437.02
	Two Adults	$1,206.84
	Employee/Child(ren)	$804.66
	Family	$1,657.40
Direct Access	**Single**	$807.04
	Two Adults	$2,040.59
	Employee/Child(ren)	$1,472.02
	Family	$2,784.57

Medical Benefits

Horizon

Below is a summary of the EPO and the OMNIA medical plans for your review.

	EPO Plan (Includes BlueCard Network)	OMNIA Plan (Includes BlueCard Network)	
Services	**In-Network Only**	**Tier 1**	**Tier 2**
Network	Advantage EPO	Omnia	
Calendar Year Deductible (Individual/Family)	$2,500 /$5,000	$500[2] /$1,000[2]	$1,250[2] /$2,500[2]
Coinsurance	Plan pays 50%	Plan pays 90%	Plan pays 80%
Calendar Year Out-of-Pocket Maximum[1] (Individual/Family)	$5,000/$10,000	$3,000[2] /$6,000[2]	$4,000[2] /$8,000[2]
PCP Office Visit	$30 copay	$10 copay	$20 copay
Specialist Office Visit	$50 copay	$20 copay	$30 copay
Preventive Care	Plan pays 100%; NO deductible (Out-of-Network: Plan pays 60%; NO DEDUCTIBLE)	Plan pays 100%; NO deductible	
Outpatient X-ray/Radiology Office Setting/Preferred Lab[3]	Plan pays 100%	Plan pays 100%	Plan pays 100%
Outpatient X-ray/Radiology Outpatient Facility	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 80% after deductible
Inpatient Hospital	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 80% after deductible
Outpatient Surgery	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 80% after deductible
Emergency Room	$100 copay, then plan pays 50% after deductible	$100 copay, then plan pays 90% after deductible	

1 Includes medical and prescription drug copays, deductible and coinsurance costs

2 Tier 1 out-of-pocket maximum accumulates to Tier 2 deductible/out-of-pocket maximum but Tier 2 deductible/out-of-pocket maximum does not accumulate to Tier 1 out-of-pocket maximum. Once Tier 2 deductible/out-of-pocket maximum have been met, Tier 1 will also have been met.

3 Horizon's preferred labs include Labcorp and Quest Diagnostics

4 The OMNIA Plan includes two network tiers of benefit. "Tier 1" is the OMNIA tier which includes Atlantic Health System, RWJBarnabas Health System, Hackensack University Health Network, Hunterdon Healthcare, Inspira Health Network, and the Summit Medical Group. "Tier 2" is the Horizon Managed Care Network and the Horizon BlueCard network.

Medical Benefits

Horizon

Below is a summary of the HDHP HSA and the Direct Access medical plans for your review.

	HDHP HSA (Includes BlueCard Network)		Direct Access (Includes BlueCard Network)	
Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Network	Direct Access		Direct Access	
Calendar Year Deductible (Individual/Family)	$2,500/$5,000[2]		$500/$1,000	$1,000 /$2,000
Coinsurance	Plan pays 80%	Plan pays 60%	Plan pays 90%	Plan pays 70%
Calendar Year Out-of-Pocket Maximum[1] (Individual/Family)	$5,000/$10,000[2]	$10,000/$20,000[2]	$5,000/$10,000	$10,000/$20,000
PCP Office Visit	Plan pays 80% after deductible	Plan pays 60% after deductible	$25 copay	Plan pays 70% after deductible
Specialist Office Visit	Plan pays 80% after deductible	Plan pays 60% after deductible	$40 copay	Plan pays 70% after deductible
Preventive Care	Plan pays 100%; NO deductible		Plan pays 100%; NO deductible	Plan pays 70%; NO deductible
Outpatient X-ray/Radiology Office Setting/Preferred Lab[3]	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 100%	Plan pays 70% after deductible
Outpatient X-ray/Radiology Outpatient Facility	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 70% after deductible
Inpatient Hospital	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 70% after deductible
Outpatient Surgery	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 70% after deductible
Emergency Room	Plan pays 80% after deductible		$50 copay, then plan pays 90%	

1 Includes medical and prescription drug copays, deductible and coinsurance costs

2 If you cover anyone other than yourself, you're considered to have "family" coverage for purposes of meeting deductibles and out-of-pocket maximums However, no one person in a family will exceed an embedded individual out-of-pocket maximum of $5,000 and the entire family is capped at $10,000. Applies to in-network services only.

3 Horizon's preferred labs include Labcorp and Quest Diagnostics

Prescription Drug Plans

Horizon/Prime Therapeutics

Below are the prescription drug benefits available to you. If you elect to participate in one of the medical plans, you are automatically enrolled in the corresponding prescription drug plan.

Prescription Drug Plans

Services	EPO, OMNIA, and Direct Access	HDHP HSA
Deductible	Prescription Drug Deductible per calendar year: $100 (Single) | $200 (all other tiers)	Integrated deductible – you must satisfy the medical plan deductible before the plan pays any coinsurance
Retail (up to a 30-day supply) Formulary Generic Formulary Brand-Name Non-Formulary Generic & Brand-Name	 $10 copay $50 copay $70 copay	 Plan pays 80% after medical plan deductible
Mail-Order (up to a 90-day supply) Formulary Generic Formulary Brand-Name Non-Formulary Generic & Brand-Name	 $20 copay $100 copay $140 copay	 Plan pays 80% after medical plan deductible

Prescription Drug Mail Order

Horizon/Amazon Pharmacy

The mail order program through Horizon, with Amazon Pharmacy, is available to help you save on your medications.

Save on Your Prescriptions With Mail Order

Using the mail order program for your maintenance medications can save you money. You will receive **up to a 90-day (3-month)** supply for two retail copays. In addition to the savings, your prescriptions will be delivered right to your home.

NOTE: You may use the mail order program if you are enrolled in any of the medical and prescription drug plans with Horizon BCBS, including the HDHP. Your medications are still subject to the deductible, but generally receive better discounts through the mail order program.

Amazon Pharmacy

Amazon Pharmacy is now a participating home delivery pharmacy. Sign up online at **www.amazon.com/horizonblue** or call **855.549.1760**. In addition to clear pricing and free shipping, Amazon Pharmacy allows you 24/7/365 access to a pharmacist.

Do you need help switching to home delivery? Call Prime Therapeutics (our Prescription Plan provider) at **877.579.7627** for assistance!

All with free standard shipping!

In addition to the savings, your prescriptions will be delivered right to your home! This will allow you to save time by ending trips to the pharmacy and waiting in line. You will also enjoy refill reminders, an auto-refill program, and ordering online or by phone.

How Much Can You Save When You Use Mail Order? **Compare for yourself...**

Retail Pharmacy	Mail Order	Annual Savings
Formulary Brand-Name Copay (per 1-month supply) **$50**	Formulary Brand-Name Copay (per 3-month supply) **$100**	**$200**
Annual cost ($50 per month x 12 fills) **$600**	Annual cost ($100per order x 4 fills per year) **$400**	

Additional Medical Resources

CancerCare

What is the CancerCARE Progam?

The CancerCARE Program is a free, fully integrated cancer solution included in YOUR FBT Gibbons medical & prescription drug plan that supports you from the first day of your diagnosis well into the stages of aftercare.

CancerCARE coordinates care and benefits for patients with new or existing cancers. Their expert medical team advocates for the best possible care in your community or at a leading national Centers of Excellence location

To Contact CancerCARE

- Phone: **877.640.9610**
- Website: **cancercareprogram.com**
- Email: **cancermanagement@cancercareprogram.com**

How Can You Benefit from CancerCARE?

Day One Help

- CancerCARE professionals are available to answer questions the day you are diagnosed.
- Help evaluate treatment options and understand next steps.
- Reduce your out-of-pocket costs and optimize your health plan benefits.

Personalized Care

- Customized treatment for each individual based on cancer type, stage, and genetic factors.
- Fully covered Genetic Testing when recommended by CancerCARE

National Resources

- Some advanced treatments are only available at Centers of Excellence.
- CancerCARE helps access national resources if they offer more benefits than local care.
- Access to clinical trials and newly approved therapies.
- CancerCARE ensures you receive the most up-to-date and effective care possible.

Expert Medical Team

- The journey begins with a registration call to gather information about your condition and insurance details.
- If appropriate, you'll be matched with a personal Oncology Nurse Expert.
- Nurses provide you with guidance, support, and answer any questions you may have.
- The entire CancerCARE team stays with you through your treatment journey, offering ongoing support and expertise.

Health Savings Account (HSA)

HSA Overview

A Health Savings Account **is only available for those enrolled in the High Deductible Health Plan (HDHP)** and who:

- Have no other first-dollar medical coverage (other types of insurance, including specific injury
or accident, disability, dental care, vision care, or long-term care are permitted);
- Are not enrolled in Medicare; and
- Cannot be claimed as a dependent on someone else's tax return.

HSA Advantages

- An HSA is portable – you own it so if you leave the company, it goes with you.
- There is no "use it or lose it" provision like there is with a Flexible Spending Account (FSA). Your money remains in the HSA year after year. Interest earnings accumulate tax deferred and if used to pay for qualified expenses, are tax free.
- You can use your HSA funds to pay for qualified expenses – with tax-free dollars!

Contribution Amounts

The maximum amount you may fund per year is established by the IRS and depends on whether you have single or family coverage in the qualified HDHP.

The 2026 Contribution Limits* are:

- $4,400 if you enroll for single coverage, and
- $8,750 if you enroll for any other tier.

* Limits may include employee and employer contributions

Anyone age 55 and older can contribute an additional "catch up" amount of up to $1,000. Contributions to the account must stop once you are enrolled in Medicare. However, you can keep the money in your account and use it to pay for medical expenses tax-free.

Flexible Spending Accounts (FSA)

Benefit Analysis, Inc. (BAI)

FBT Gibbons provides you the opportunity to pay for out-of-pocket medical, dental, vision and dependent care expenses with pre-tax dollars through the Flexible Spending Accounts. You can save approximately 25% of each dollar spent on these expenses when you participate in an FSA.

FSA Contributions

Contributions to your FSA are deducted from your paycheck before any taxes are taken out. This means that you don't pay federal income tax, Social Security taxes and state and local income taxes on the portion of your paycheck you contribute to your FSA.

Use-It-or-Lose-It

You should contribute the amount of money you expect to pay out-of-pocket for eligible expenses for the plan period. If you do not use the money you contributed, it will not be refunded to you or carried forward to a future plan year. **This is the "use-it-or-lose-it" rule.**

Healthcare FSA

A Healthcare FSA is used to reimburse out-of-pocket medical expenses incurred by you and your dependents. **The 2026 plan year maximum you can contribute to the Healthcare FSA is $1,983.**

Limited Purpose FSA

Available to HSA participants only. The IRS allows members who participate in a Health Savings Account to also elect a Limited Purpose FSA. Limited Purpose FSA participants may contribute up to **$1,983 to be used for eligible dental and vision expenses only.**

Dental Benefits

Horizon

Below is a summary of the three dental plans available to you. The dental plans are offered on a voluntary basis, which means the employee is responsible for 100% of the premiums. If you need help finding a participating dental provider, please visit **www.horizonblue.com**.

	Dental Choice Plan H*	Dental Option		Dental Option Plus	
Services	**In-Network****	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible (Individual/Family)	None	$50/$150		$50/$150	
Annual Maximum (per patient)	None	$1,500		$2,000	
Office Visit	$5 copay	N/A		N/A	
Preventive & Diagnostic Exams X-rays (full mouth series or panoramic)	Refer to schedule of benefits	Plan pays 100%; NO deductible	Plan pays 80%; NO deductible	Plan pays 100%; NO deductible	Plan pays 80%; NO deductible
Basic Services	Refer to schedule of benefits	Plan pays 80% after deductible		Plan pays 80% after deductible	
Major Services Crowns, Bridgework, Inlays, Full & Partial Dentures	Refer to schedule of benefits	Plan pays 50% after deductible		Plan pays 50% after deductible	
Orthodontia Benefits (to age 19)	Refer to fee schedule of benefits (limited to one complete orthodontic treatment per lifetime)	Not Covered		Plan pays 50%	
Orthodontia Lifetime Maximum		Not Covered		$2,000	

* MUST choose a primary dentist via ADP

** Please note: The Dental Choice plan network only includes New Jersey dentists.

Employee Monthly Dental Contributions

Coverage Tier	Dental Choice Plan H	Dental Option	Dental Option Plus
Single	$33.33	$56.87	$66.12
Two Adults	$66.96	$114.17	$132.74
Employee/Child(ren)	$69.26	$104.84	$121.89
Family	$102.63	$162.14	$188.52

Vision Benefits

VSP

About the Vision Plan Options

Below is a summary of the two vision plans available to you. The vision plans are offered on a voluntary basis, which means the employee is responsible for 100% of the premiums. If you need help finding a participating vision provider, please visit **www.vsp.com**.

	VSP Signature		VSP Enhanced	
Vision Benefits	**In-Network**	**Out-of-Network Reimbursement**	**In-Network**	**Out-of-Network Reimbursement**
Exam	$10 copay	Up to $50	$10 copay	Up to $50
Frames	$130 allowance	Up to $70	$200 allowance	Up to $70
Lenses Single Vision Lenses Bifocal Lenses Trifocal Lenses Lenticular Lenses	 $25 copay $25 copay $25 copay $25 copay	 Up to $50 Up to $75 Up to $100 Up to $125	 $25 copay $25 copay $25 copay $25 copay	 Up to $50 Up to $75 Up to $100 Up to $125
Contact Lenses (in lieu of eyeglasses)	$130 allowance	Up to $70	$250 allowance	Up to $105
Frequency Vision Exam Lenses Frames	 12 months 12 months 24 months		 12 months 12 months 24 months	
Second Pair[1]	N/A		Matches in-network coverage for first pair after $20 copay	Matches out-of-network reimbursement for first pair
VSP LightCare[2]	N/A		Covered-in-full after exam copay, up to $200 allowance	N/A

1 Second pair of glasses or contact lenses

2 VSP LightCare: The light care benefit can be substituted for your first pair of frames. You also have the option to use light care as your second pair of frames.

Employee Monthly Vision Contributions

Coverage Tier	VSP Signature	VSP Enhanced
Single	$8.94	$15.81
Two Adults	$14.31	$25.30
Employee/Child(ren)	$14.61	$25.83
Family	$23.55	$41.64

Basic Life and AD&D

Sun Life

Life Insurance

All active, full-time employees working at least 30 hours per week are eligible for the basic life and accidental death and dismemberment (AD&D) plan. This plan is available at no cost - the firm pays 100% of the basic life and AD&D premium.

Supplemental Life Insurance

All active, full-time employees working at least 30 hours per week are eligible to purchase supplemental coverage. **Since this plan is optional, you are responsible for 100% of the premium.** Coverage may be purchased for you, your spouse, and your dependent child(ren).

Please Note: Employee coverage must be purchased in order to elect spouse or child coverage.

Employee:

- Increments of $10,000 up to the lesser of 5x annual earnings or $500,000
- Guarantee Issue (with in the first 30 days of initial eligibility): $300,000

Spouse:

- Increments of $5,000 up to the lesser of $100,000 or 50% of employee coverage
- Guarantee Issue (with in the first 30 days of initial eligibility): $30,000 (or $1,000 if age 60+)

Child(ren):

- Increments of $2,500 up to lesser of $500,000 or 50% of employee coverage
- Full child benefits begin at age 6 months

If you do not make an election during your initial eligibility period and wish to enroll at a later date, such as the next Open Enrollment period, you will be subject to medical underwriting, otherwise known as Evidence of Insurability (EOI).

Voluntary Benefits

Accident: Sun Life

- 24-Hour coverage pays specified benefits for expenses incurred as a result of an accidental injury for employees, spouses & children
- Helps employees cover out-of-pocket costs that health insurance doesn't pay such as co-pays, deductibles, emergency room fees and transportation, and lodging expenses.
- Guaranteed Issue for employee, spouse & children
- More than 30 Benefit Triggers for accident related treatment, paid in addition to any other medical or supplemental benefits received, including:
  - Indemnity coverage for fractures, dislocations, lacerations, eye injury, burns, brain injury, etc.
  - Emergency Medical Expenses and Follow-up Treatment benefits
  - Initial Hospitalization, Hospital Admission & Daily Hospital Confinement benefits
  - Outpatient Physicians Treatment pays for each office visit for any reason (2x per year)
  - Diagnostic Exams, Tendon/Ligament/Rotator Cuff Surgery and Physical Therapy
  - Accidental Death & Dismemberment coverage
  - Portable coverage that can be continued if the employee changes jobs

Critical Illness: Sun Life*

- Pays a lump sum benefit directly to the insured, regardless of other medical or supplemental coverage.
- Covered conditions include Cancer, Heart Attack, Stroke, Major Organ Failure, and more.
- Employee and Spouse Benefit Options Available: $10,000, $20,000, $30,000 and a $40,000 benefit
- Children Benefit Options Available: $5,000, $10,000, $15,000 and $20,000
- Guaranteed Issue:
  - Employee: $40,000
  - Spouse: $40,000
  - Child: $20,000
- Dependent children are covered from birth to their 26th birthday.
- Plan pays up to 100% of the benefit amount depending on your illness or diagnosis.
- $50 Annual Wellness Screening benefit included.
- Portable- individual coverage can continue if an employee leaves their job or retires.

* The Plan excludes any pre existing conditions for the first 12 months of your coverage. A pre-existing condition includes anything you have sought treatment for in the 3 months prior to your insurance becoming effective. Treatment can include consultation, advice, care, services or a prescription for drugs or medicine.

Voluntary Benefits

Hospital Indemnity: Sun Life

- First Day Hospital Confinement Benefit
- Daily Hospital Confinement Benefit
- Hospital Intensive Care Benefit (30 day maximum for each day of continuous hospital confinement). Paid in addition to First Day Hospital and Daily Hospital.
- Guaranteed Issue coverage for Employee, Spouse and Child(ren)
- No pre-existing conditions limitation
- Dependent children are covered from birth to their 26th birthday
- Continuation of Coverage is available if employment ends

Pet Insurance: Nationwide

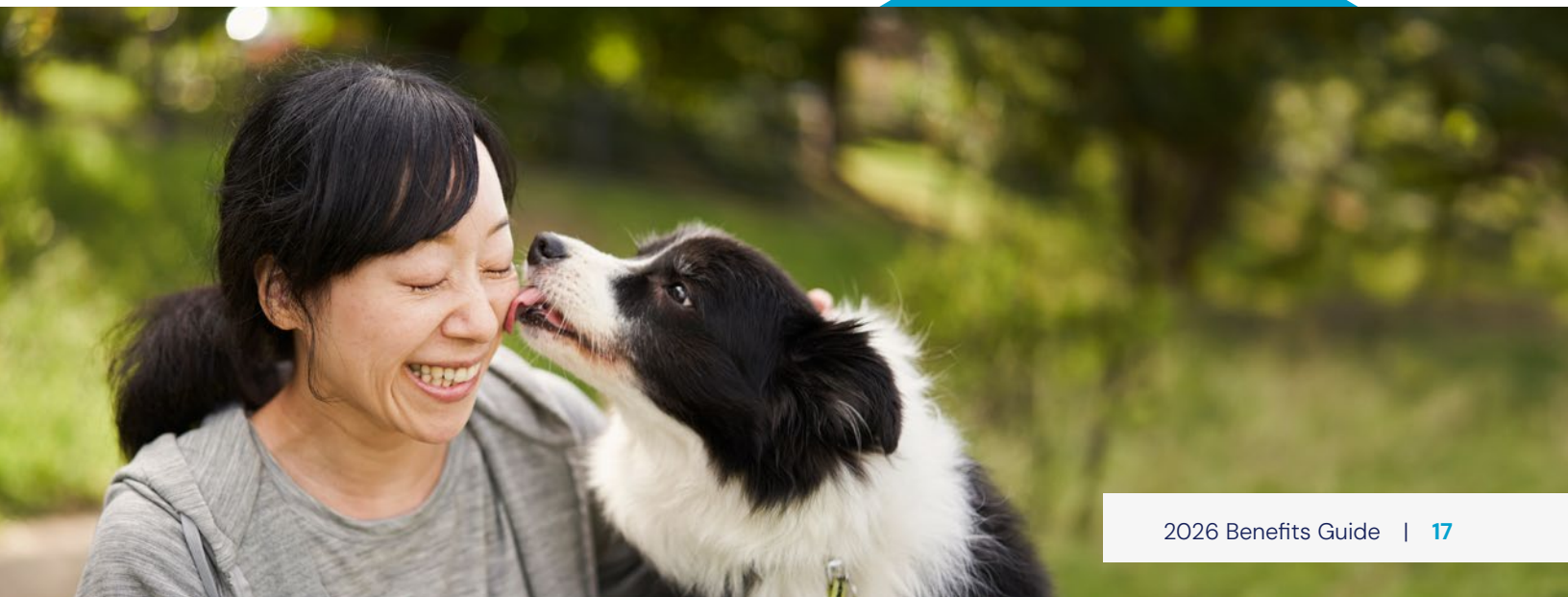
- Rates are based on species of your pet and the state in which you live
- Pre-existing conditions are excluded
- If you elect this benefit, you will be billed directly from Nationwide
- Premiums are guaranteed for one year, as long as your policy remains in force and the state does not change rates
- Can enroll at anytime during the year
- Please contact Nationwide at **1.877.738.7874** to enroll. You may also enroll via their website: **www.petinsurance.com/gibbonslaw**

Telemedicine: Healthiest You

Provides 24-hour access to physicians via phone, video, or email for the diagnosis and treatment of illness, second opinions, and common conditions.

After enrollment, Healthiest You members have immediate access to:

- Board-certified, US-based doctors by phone, online video, or email with NO consultation fees!
- Safe, secure and confidential medical advice and information
- A personalized wellness program- members can get healthy with access on the web or phone app.
- Online prescription medication pricing engine- no overpaying for prescriptions anymore.
- At an additional cost, consultations are included for the following:
  - Behavioral Health (therapist): $90 per consult
  - Behavioral Health (psychiatrist): $220 initial consult and $100 for each ongoing consult
  - Dermatology: $85 per consult
  - Nutrition: $59 per consult
- Employee cost is **$9.40** per month



Medicare

What you need to know

What Are My Options for Coverage?

We understand that not everyone approaches their health insurance coverage the same. Maybe cost is your biggest concern or health issues may have you more focused on the benefits. That's why it's good to have choices.

- **Original Medicare (includes Medicare Part A and Part B):**
  - Medicare Part A covers inpatient hospital care, skilled nursing facility, hospice, lab tests, surgery, and home health care.
  - Medicare Part B covers doctor and other health care providers' services and outpatient care. Part B also covers durable medical equipment, home health care, and some preventive services.
- **Medicare Advantage Plans (Part C):** Covers your Medicare Part A and Part B services and may include additional benefits like dental, vision, and prescription drug coverage.
- **Medicare Prescription Plans (Part D):** Covers the cost of certain generic and brand name prescription medications.
- **Medicare Supplement Plans (Medigap):** Supplemental health insurance plans offered by private insurance companies that lower your out-of-pocket costs by paying a portion of covered services that original Medicare leaves you to pay.

Where Can I Get More Information or Help?

It can be confusing when it comes to navigating your way around Medicare. We have several resources available to you:

- **SmartConnect consultants can help you research, compare, and purchase Medicare insurance plans:**
  - Call: **855.984.5833** (Monday - Friday, 7:30 am to 5:00 pm, CT)
  - Via the web: **connect.smartmatch.com/connerstrong**
- **Medicare by Savoy consultants are also available to assist in providing quotes and comparing Medical options:**
  - Call: **833.600.6727** (Monday - Friday, 9:00 am to 5:00 pm)
  - Email: **experts@medicarebysavoy.com**
- **In addition, the following resources are available:**
  - Call: **1.800.MEDICARE** (**800.633.4227**)
  - Visit the Medicare website at **www.medicare.gov**
  - Download the "Medicare & You" handbook that can be found on **www.medicare.gov** or request a copy by calling **1.800.MEDICARE**

Benefits Member Advocacy Center

Conner Strong & Buckelew

Don't get lost in a sea of benefits confusion! With just one call or click, the Benefits MAC can help guide the way!

The Benefits Member Advocacy Center (Benefits MAC), provided by Conner Strong & Buckelew, can help you and your covered family members navigate your benefits. Contact the Benefits MAC to:

- Find answers to your benefits questions
- Search for participating network providers
- Clarify information received from a provider or your insurance company, such as a bill, claim, or explanation of benefits (EOB)
- Rescue you from a benefits problem you've been working on
- Discover all that your benefit plans have to offer

Member Advocates are available Monday through Friday, 8:30am to 5:00pm (Eastern Time). After hours, you will be able to leave a message with a live representative and receive a response by phone or email during business hours within 24 to 48 hours of your inquiry.

Contact Benefits MAC

You may contact the Member Advocacy Team in any of the following ways:

- Via phone: **800.563.9929**, Monday through Friday, 8:30 am to 5:00 pm (Eastern Time)
- Via the web: **www.connerstrong.com/memberadvocacy**
- Via fax: **856.685.2253**
- Via email: **cssteam@connestrong.com**

BenePortal

Online Benefits Resource

Your benefits information in one place!

At FBT Gibbons, you have access to a full-range of valuable employee benefit programs. With the Online Resource Center, you and your dependents can review your current employee benefit plan options online, 24 hours a day, 7 days a week!

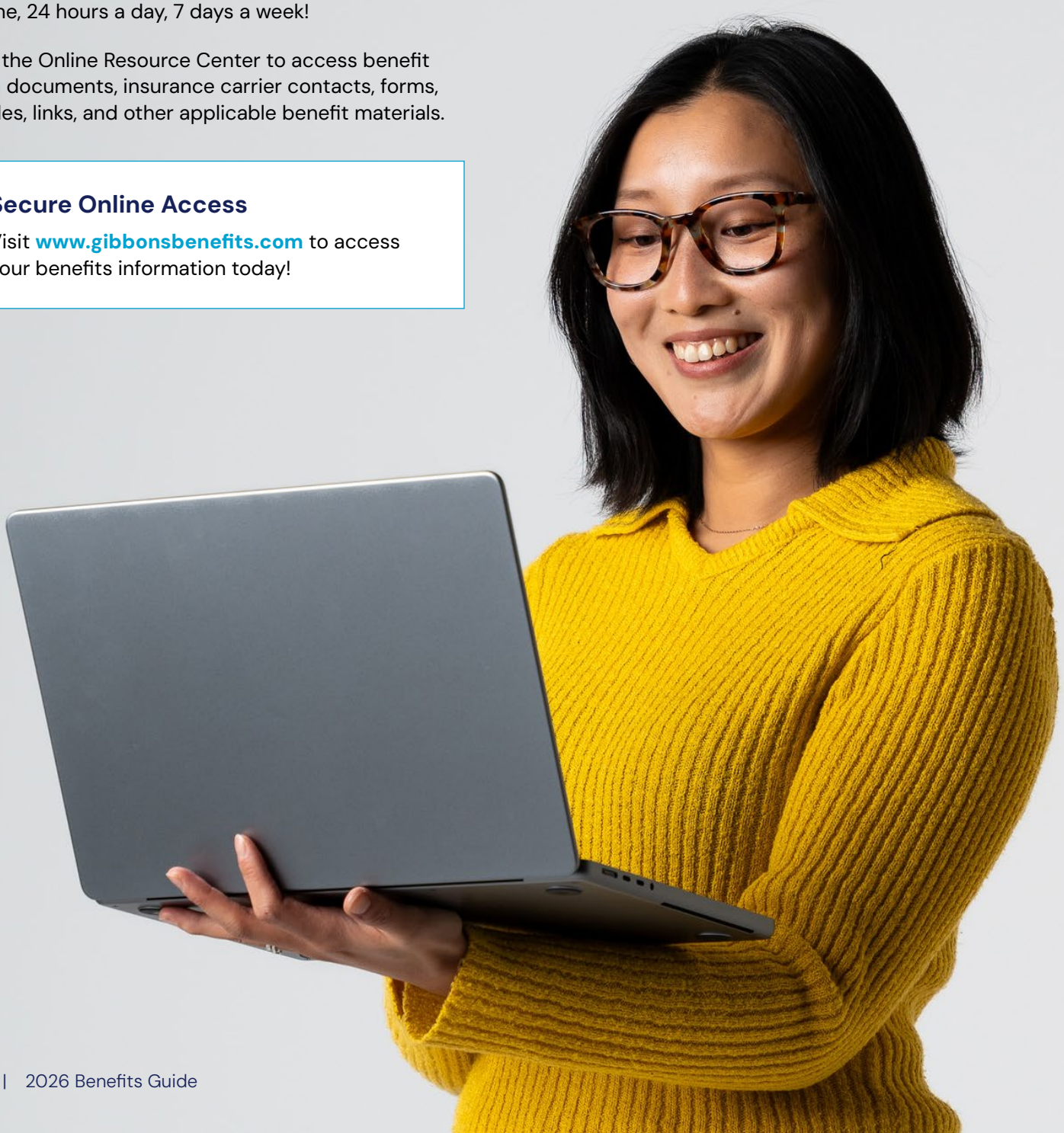
Use the Online Resource Center to access benefit plan documents, insurance carrier contacts, forms, guides, links, and other applicable benefit materials.

Secure Online Access

Visit **www.gibbonsbenefits.com** to access your benefits information today!

Mobile-Friendly Site

The Online Resource Center is mobile-optimized, making it easy to view your benefits on-the-go. Simply bookmark the site in your phone's browser or save it to your home screen for quick access.



Carrier Contacts

Benefits/Resources	Contact	Phone	Website
Medical/Pharmacy	Horizon	800-355-2583	www.horizonblue.com
Dental	Horizon	800-355-2583	www.horizonblue.com
Vision	VSP	800-877-7195	www.vsp.com
FSA/Limited Purpose FSA	Benefit Analysis, Inc. (BAI)	973-661-2424	www.benefitanalysis.com
Life & Disability	Sun Life	800-247-6875	www.sunlife.com
Accident, Critical Illness, & Hospital Indemnity	Sun Life	800-247-6875	www.sunlife.com
CancerCARE	CancerCARE	877-640-9610	www.cancercareprogram.com
Telemedicine	Healthiest You	866-703-1259	www.healthiestyou.com
Pet Insurance	Nationwide	800-540-2016	www.petinsurance.com/gibbonslaw

Glossary of Benefit Terms

Balance Billing: Balance billing, sometimes called surprise billing, is a medical bill from a healthcare provider billing a patient for the difference between the total cost of services being charged and the amount the insurance pays.

Coinsurance: The amount or percentage that you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met, and can vary based on the plan design.

Copayment: A flat fee you pay toward the cost of covered medical services.

Coverage Tier: There are four types of coverage tiers: employee, employee + spouse, employee + child(ren), and family. If you are not enrolled in the single coverage tier you are considered family and the family deductible will apply.

Deductible: A specific dollar amount you pay out-of-pocket before the insurance company will pay any expense. Under some plans, the deductible is waived for certain services.

Dependent: A person who qualifies for and is enrolled in a health plan to receive benefits because of their relationship to the insured employee.

Flexible Spending Account (FSA)

- Healthcare FSA: An account an individual establishes through his or her employer to pay for out-of-pocket medical expenses with tax-free dollars. These expenses include insurance copays and deductibles, and qualified prescription drugs, dental, and vision expenses. The maximum contribution to an FSA is determined by the IRS and must be used within a given plan year.
- Limited Purpose FSA: Allows you to set aside money from your paycheck on a pretax basis to pay for out-of-pocket dental and vision costs. The limited purpose FSA is for individuals who are also enrolled in an HSA account.

Generic Medication: Has the same active ingredient as a brand name drug, however, it is more cost effective. The FDA rates these medications to be as safe and as effective as brand name medications.

Health Savings Account (HSA): An employee-owned medical savings account used to pay for eligible medical expenses. Funds contributed to the account are pre-tax and do not have to be used within a specified time frame. HSAs must be coupled with the enrollment in a high-deductible health plan (HDHP).

High Deductible Health Plan (HDHP): A qualified health plan the combines reasonable monthly premiums in exchange for higher deductibles and out-of-pocket limits. These plans are often coupled with an HSA.

In-Network: Healthcare providers that have contracted with a particular health insurance plan to provide services at pre-negotiated rates.

Inpatient: A person who is treated as a registered patient in a hospital or other health care facility.

Medically Necessary (or medical necessity): Services or supplies provided by a hospital, health care facility, or physician that meet the following criteria: (1) are appropriate for the symptoms and diagnosis and/or treatment of the condition, illness, disease, or injury; (2) serve to provide diagnoses or direct care and/or treatment of the condition, illness, disease, or injury; (3) are in accordance with standards of good medical practice; (4) are not primarily service as convenience; and (5) are considered the most appropriate care available.

Medicare: An insurance program administered by the federal government to provide health coverage to individuals age 65 and older, or who have certain disabilities or illnesses.

Glossary of Benefit Terms

Member: You and those covered become members when you enroll in a health plan. This includes eligible employees, their dependents, COBRA beneficiaries, and surviving spouses.

Out-of-Network: Health care providers that do not have a contractual agreement with a particular health insurance plan. As a result, out-of-network providers typically result in higher out-of-pocket cost for insured individuals.

Out-of-Pocket Expenses: Amount that you must pay toward the cost of health care services. This includes deductibles, copayments, and coinsurance.

Out-of-Pocket Maximum (OOPM): The highest out-of-pocket amount that you can be required to pay for covered services during a benefit period.

Preferred Brand vs. Non-Preferred Brand Medication: Often two brand name drugs that help treat the same problem, but one has been shown to be more cost - or medically effective than the other. That more effective drug becomes a preferred drug and the other becomes a non-preferred drug.

Preferred Provider Organization (PPO): A health plan that contracts to create a network offering both in– and out-of-network coverage. Members pay less when using in-network providers.

Premium: The amount you pay for a health plan in exchange for coverage. Health plans with higher deductibles typically have lower premiums.

Preventive Care: Most preventive care is covered under the Affordable Care Act (ACA). Find what is covered at www.healthcare.gov/coverage/preventive-care-benefits.

Primary Care Physician (PCP): A doctor that is selected to coordinate treatment under your health plan. This generally includes family practice physicians, general practitioners, internists, pediatricians, etc.

Prior Authorizations: Also known as preauthorization or precertification, this process requires physicians and other healthcare providers to obtain approval from a health plan before delivering a specific service to the patient.

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Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

FBT Gibbons offers a series of health coverage options. You will receive a Summary of Benefits and Coverage (SBC) from Horizon. These documents summarize important information about all health coverage options in a standard format. Please contact Human Resources if you have any questions.

Notice Regarding Special Enrollment

Loss of other Coverage (excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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 Company stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program (CHIP).

New dependent by marriage, birth, adoption, or placement for adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you request a change due to a special enrollment event within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program (CHIP) with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact Rebecca Hurst, Director of Benefits and Payroll at 973-849-1727.

Newborns' and Mothers' 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

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 benefits. If you have any questions, please speak with Human Resources.

Mental Health Parity and Addiction Equality Act of 2008

This Act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

General Notice of COBRA Continuation Coverage Rights

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan.

This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;

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- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the COBRA vendor.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below.
For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
Rebecca Hurst
Director of Payroll and Benefits
973-849-1727
rhurst@fbtgibbons.com
One Gateway Center
Newark, New Jersey 07102

Important Notice from FBT Gibbons About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with FBT Gibbons and about 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 current 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 current 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. FBT Gibbons has determined that the prescription drug coverage offered is, 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 existing 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 current 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 Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current FBT Gibbons coverage will be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage. (See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D).

If you do decide to join a Medicare drug plan and drop your current FBT Gibbons coverage, be aware that you and your dependents will be able to get this coverage back if there is a Life Event or at open enrollment.

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 current coverage with FBT Gibbons and don't join a Medicare drug plan within 63 continuous days after your current 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

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October to join.

For More Information About This Notice Or Your Current 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 through FBT Gibbons 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).

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility –

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

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

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

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

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

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

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

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid
Website: 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 Website:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/medicaid/plans-programs/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/medicaid/plans-programs/fee-service/health-insurance-premium-payment-program
HIPP Phone: 1-888-346-9562

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

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

LOUISIANA – Medicaid
Louisiana Medicaid Website:
https://www.ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: 1-888-342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP) Website:
https://www.ldh.la.gov/lahipp
LaHIPP phone: 1-877-697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: 1-888-716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

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

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

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

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

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

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

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

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

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

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

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

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

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

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

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

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

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

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

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

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

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

West Virginia – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

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

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

To see if any other states have added a premium assistance program since January 31, 2026, 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

Insurance Marketplace Notice

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact the insurance carrier's customer service number located on your ID card. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area. To get information about the Marketplace coverage, you can call the government's 24/7 Help-Line at 1-800-318-2596 or go to https://www.healthcare.gov/marketplace/individual/.

PART B: Information about Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

3. Employer Name Gibbons P.C.		4. Employer Identification Number (EIN) 22-2366099
5. Employer Address One Gateway Center		6. Employer phone number 973-596-4500
7. City Newark	8. State NJ	9. Zip Code 07102
10. Who can we contact about employee health coverage at this job? Rebecca Hurst		
11. Phone number (if different from above) 973-849-1727	12. Email address rhurst@fbtgibbons.com	

Notes

FBT Gibbons