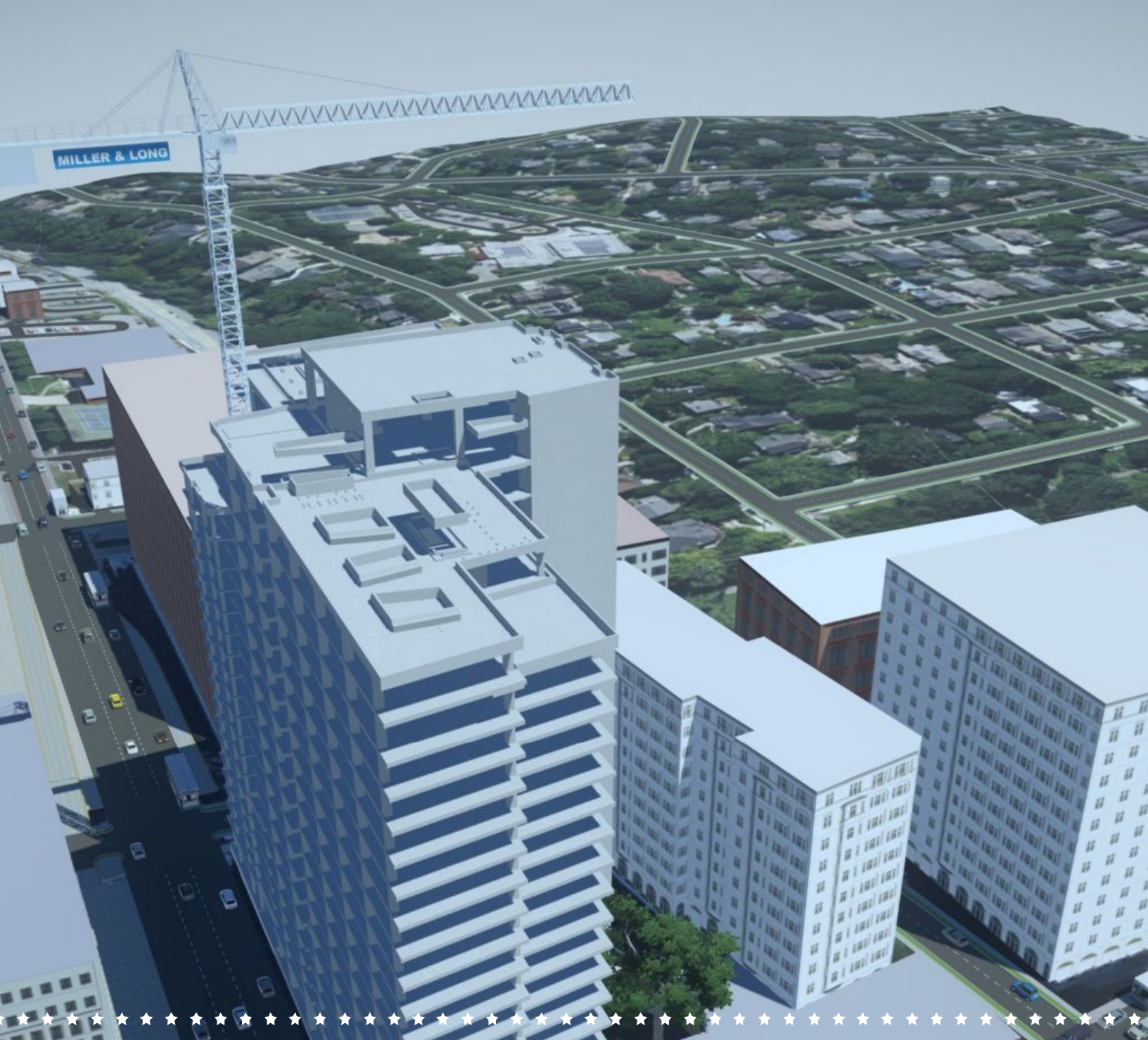




MILLER & LONG
2025 BENEFITS GUIDE
HOURLY AND SALARY EMPLOYEES

WELCOME TO MILLER & LONG

This is your opportunity to review and enroll in the Miller & Long benefits package. We encourage you to take the time to carefully review the information in this guide to ensure that you make the best benefit decisions for you and your family.

Once you have submitted your final elections, you will not be able to change them until the next Open Enrollment period, unless you experience a qualifying life event.

We encourage you to take the time to carefully review the information in this guide to ensure that you make the best benefit decisions for you and your family.

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QUESTIONS?

If you have any questions about the benefits outlined in this guide or the enrollment process, don't forget that the following resources are available:

Benefits MAC

Contact the Benefits Member Advocacy Center (Benefits MAC) for any benefit-related questions, Monday—Friday 8:30 am—5:00 pm (Eastern Time) at **1.800.563.9929**.

Additional informational flyers are included



ELIGIBILITY AND QUALIFYING LIFE EVENTS

WHO IS ELIGIBLE?

The benefits outlined in this guide are available to all Miller & Long full-time employees working 30 or more hours per week.

DON'T FORGET

You can only make changes to your benefit elections during the open enrollment period, unless you experience a Qualifying Life Event.

QUALIFYING LIFE EVENTS

The following circumstances are some of the reasons you may change or modify your enrollment during the plan year:

- Marriage
- Birth & Adoption
- Divorce or Legal Separation
- Death of spouse or dependent
- Change in coverage through a spouse's plan
- Loss of dependent status
- Gain/loss of eligibility for Medicare or Medicaid
- Gain/loss of eligibility for a Children's Health Insurance Program (CHIP)
- Receiving a Qualified Medical Child Support Order (QMCSO)

These special circumstances, often referred to as Qualifying Life Events or life event changes, will allow you to make plan changes at any time during the year in which they occur. **For any allowable changes, you must inform Human Resources, within 30 calendar days of the event to avoid a lapse in coverage.**



WEEKLY MEDICAL, PRESCRIPTION, VISION AND DENTAL CONTRIBUTIONS

	MEDICAL/ RX	DENTAL	VISION
EMPLOYEE	\$36.18	\$7.49	\$1.32
EMPLOYEE + SPOUSE	\$90.97	\$17.97	\$2.51
EMPLOYEE + CHILD(REN)	\$67.61	\$13.48	\$2.64
EMPLOYEE + FAMILY	\$144.04	\$28.45	\$3.89

IMPORTANT CONTACTS

If you have any questions about other company benefits, please contact your Human Resources Department.

BENEFITS/RESOURCES	CONTACT	PHONE NUMBER	WEBSITE
MEDICAL/ RX	Kaiser Permanente	301.468.6000	www.kaiserpermanente.org
DENTAL	Delta Dental	844.697.0578	www.deltadental.com
VISION	EyeMed	866.939.3633	www.eyemed.com
LIFE/AD&D , STD & LTD	Prudential	Contact Human Resources	www.prudential.com
FLEXIBLE SPENDING ACCOUNTS	Flexible Benefit	888.345.7990	www.myflexaccount.com
BENEFITS MEMBER ADVOCACY CENTER HOTLINE	Conner Strong & Buckelew	800.563.9929	www.connerstrong.com/ memberadvocacy



MEDICAL PLAN: KAISER PERMANENTE

Eligible employees have the option to enroll in our medical plan through Kaiser.

KAISER HMO PLAN

IN-NETWORK			
ANNUAL DEDUCTIBLE <i>Individual/Family</i>	\$1,500 / \$3,000		
ANNUAL OUT-OF-POCKET MAXIMUM <i>Individual/Family</i>	\$3,000 / \$6,000		
PREVENTIVE CARE Routine Physicals, Pap Tests, Well Child Care, Immunizations, Flu Shots, etc.	Plan pays 100%		
OFFICE VISITS Primary Care Physician (PCP) Specialist	\$25 copay, no deductible \$35 copay, no deductible		
DIAGNOSTIC LABORATORY	Plan pays 100%		
DIAGNOSTIC X-RAY/IMAGING (MRI, CT Scan)	\$100 Copay after deductible		
EMERGENCY ROOM	\$150 copay, no deductible		
URGENT CARE CENTER	\$35 Copay, no deductible		
INPATIENT HOSPITAL	\$250 Copay after deductible		
OUTPATIENT SURGERY	Plan pays 100% after deductible		
TELEHEALTH	Plan pays 100%		
PRESCRIPTION BENEFITS	RETAIL PHARMACY		MAIL-ORDER
	<i>Kaiser Pharmacy</i>	<i>Participating Pharmacy</i>	<i>(Up to a 90-day supply)</i>
GENERIC	\$10 copay	\$20 copay	\$20 copay
FORMULARY BRAND	\$20 copay	\$35 copay	\$40 copay
NON-FORMULARY BRAND	\$35 copay	\$50 copay	\$70 copay

* You are entitled to a combined 10 out of network services/visits per year. More information is available upon request.

Blood pressure
Cholesterol
Diabetes
Breast cancer
Colorectal cancer
Prostate cancer
Thyroid disease
Glaucoma

Don't Forget: Preventive Care Services are covered 100% in-network—no copays or coinsurance!

The screenings to the left represent just some of the preventive care screenings available through our medical plans. Don't guess when it comes to your health—make the most of your healthcare investment and take advantage of the preventive care services that are covered 100% in-network.

GETTING STARTED WITH KAISER PERMANENTE

Members have the option to complete their Kaiser Permanente onboarding on kp.org, but if you need assistance, you can call the New Member Activation Desk at [855-392-4851](tel:855-392-4851).

Step 1: Choose their doctor— and change anytime

- We ask all new members to get started by selecting their Permanente doctor.
- Members can browse all Permanente doctors at kp.org/doctor before making their selection.
- Members can choose their doctor by:
 - Selecting a doctor on kp.org/doctor, calling Members Services, or the New Member Activation Desk.

Members can change their doctor at any time, for any reason.

Step 2: Activate their account on kp.org

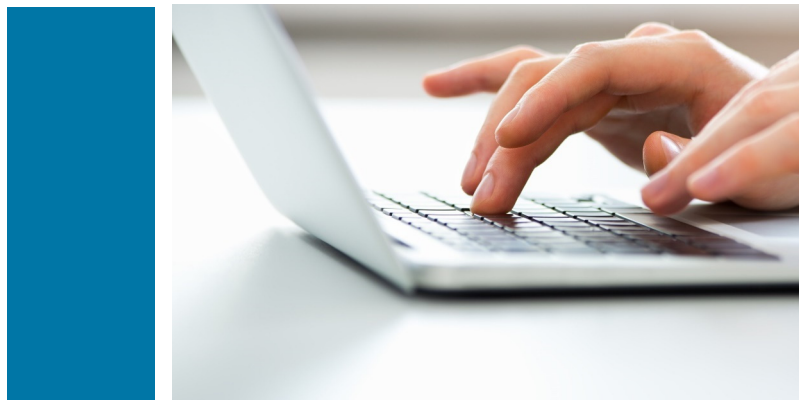
- What benefits do members receive when they activate on kp.org?
 - Members can complete an e-visit, chat with a nurse, and video visit with a physician.
 - View most lab results.
 - Refill most prescriptions and enroll in prescription home delivery.
 - Email their doctor's office with nonurgent questions.
 - Schedule and cancel routine appointments with their primary care physician (PCP).
 - Select specialists.
 - Print vaccination records for school, sports, and camp.
 - Manage a family member's health care.
 - Get personalized cost estimates for labs, prescriptions and other medical services.
 - And much more.
- To activate, members can go to kp.org/newmember. They will need their medical record number to register, which is located on their Member ID card.
- Members can also download the Kaiser Permanente app so they can access their Kaiser Permanente membership on the go and perform most of the items above.

Step 3: Transfer their prescriptions

- Members have several ways to transfer their prescriptions to a Kaiser Permanente pharmacy:
 - Go to kp.org/newmember and follow the steps to complete the prescription transfer online form.
 - Choose a Kaiser Permanente pharmacy at kp.org/facilities and call the pharmacy to transfer their prescriptions. Members don't have to wait until they are onboarded to transfer their prescriptions.
 - Call the New Member Activation Desk and they will connect the member to a Pharmacy team agent to transfer their prescriptions.
- Once a member transfers their prescriptions, they can sign up to for the Kaiser Permanente prescription home delivery service. Which allows members to receive their prescriptions at their home within 3-5 business days. To sign-up, members can call [800-733-6345](tel:8007336345) or go to kp.org to order online and choose the mail option.

Step 4: Transfer their medical Records

- In order to make a member's transition to Kaiser Permanente as seamless as possible, we recommend transferring their medical records.
- Once member consults with their Permanente physician on which records should be transferred, they will receive a Targeted Authorization form. The member's Permanente physician will complete the form and then the member will need submit it to their former physician.
- The requested records can be mailed to the member's Permanente physician, or the member may bring them in to their preferred Kaiser Permanente medical center.



NEED A QUICKER PATH TO CARE?

Choose a Get Care Now option from Kaiser Permanente

Discover our range of 24/7 virtual care services, including E-visits, Get Care Now with a Clinician, and Chat with KP

With our online options, you can get care from the comfort of home—within 2 hours. But which option is right for you? Here's your guide to each service:

SERVICE	WHAT IS IT?	THIS OPTION IS GOOD FOR MEMBERS WHO
E-VISIT	Answer some basic questions online and receive advice from a physician	Want to get care on their own time for non-urgent medical needs like sore throat, cold/flu, rash, and more.
GET CARE NOW WITH A CLINICIAN	Video or phone visit with a physician for urgent care—no appointment needed	Want to speak with a physician for urgent care but don't need to be seen in person; this is also a great option when traveling
CHAT WITH KP	Chat with a nurse for care advice or member services for plan information	Feel unsure about where to start or how to access care

GET ONLINE CARE FOR THESE HEALTH MATTERS AND MORE:

- Cold, sinus, and flu-like symptoms
- COVID-19 testing and immunizations
- Emergency contraception²
- Herpes (cold sores or genital)²
- Influenza (flu) shot scheduling
- International travel immunization
- Mental wellness (anxiety and/or depression)²
- Rash (ages 2 months and up)
- STI (sexually transmitted infection) testing²
- Urinary symptoms²
- Vaginal discharge²
- Work or school notes
- And more

Ready to get started?

Learn more about these services and our other virtual care options at kp.org/getcare or sign in to your KP account and click Get Care Now.



VISION & DENTAL BENEFITS

EYEMED VISION PLAN

Miller & Long employees that enroll in medical insurance will be enrolled in the EyeMed vision plan.

	IN-NETWORK	OUT-OF-NETWORK
EYE EXAM	\$0 copay	Up to \$45
MATERIALS	\$0 copay	Not Applicable
FRAME RETAIL ALLOWANCE	Up to \$110	Up to \$61
LENSES		
Single Vision Lenses	Covered in full	Up to \$32
Bifocal Lenses	Covered in full	Up to \$55
Trifocal Lenses	Covered in full	Up to \$65
Lenticular Lenses	Covered in full	Up to \$80
CONTACT LENSES <i>(in lieu of eyeglasses)</i>	Up to \$110	Up to \$98
FREQUENCY		
Vision Exam	12 months	12 months
Lenses	12 months	12 months
Trifocal Lenses	12 months	12 months

* Safety Glasses - an allowance of up to \$50 is provided for one pair per year

DELTA DENTAL BENEFITS

Miller & Long employees have the option to enroll in dental coverage through Delta Dental.

	IN-NETWORK	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLES <i>Individual/Family</i>	\$25 / \$75	\$25 / \$75
CALENDAR YEAR MAXIMUM <i>(per patient)</i>	\$2,000	\$2,000
PREVENTIVE & DIAGNOSTIC SERVICES Exams, cleanings, bitewing x-rays, fluoride treatment	100% no deductible	80% no deductible
BASIC SERVICES Fillings, endodontics, periodontics, oral surgery, sealants	100% after deductible	80% after deductible
MAJOR SERVICES Crowns, gold restorations, bridgework, full and partial dentures, implants	50% after deductible	50% after deductible
ORTHODONTIA BENEFITS <i>(Employees & Dependents)</i>	50%	50%
ORTHODONTIA LIFETIME MAXIMUM <i>(per patient)</i>	\$2,500	\$2,500

LIFE AND DISABILITY BENEFITS: PRUDENTIAL

For specific information regarding your individual life and disability benefits, please reference the handout included with your open enrollment materials. Remember to take the time to review your designated life insurance beneficiary.

WHO CAN BE A LIFE INSURANCE BENEFICIARY?

Here are some situations to consider when naming your life insurance beneficiaries:

- *Spouse*
- *Family members*
- *Friends*
- *Minors*
- *Financial relationships*
- *A charity*
- *A trust*
- *Your estate*

FLEXIBLE SPENDING ACCOUNTS

Miller & Long provides you with the opportunity to pay for out-of-pocket medical, dental, vision and dependent care expenses with pre-tax dollars through the Flexible Spending Accounts (FSA). **The FSA plan year runs from January 1, 2025 to December 31, 2025.** You must participate in open enrollment and indicate your contribution for the new plan year. Your election from last year will not be carried over.

HEALTHCARE FSA

Employees can set aside additional funds into this account on a tax free basis up to \$3,300.

Eligible expenses include:

- Doctor office copays
- Non-cosmetic dental procedures (crowns, dentures, orthodontics)
- Prescription contact lenses, glasses and sunglasses
- LASIK eye surgery

DEPENDENT CARE FSA

The Dependent Care FSA is used to reimburse expenses related to the care of eligible dependents. The maximum that you can contribute to the Dependent Care FSA is \$5,000 if you are a single employee or married filing jointly. If you are a married employee filing separately the maximum you can contribute is \$2,500.

Eligible expenses include:

- Au Pair
- After school programs
- Baby-sitting/dependent care to allow you to work or actively seek employment
- Day camps and preschool
- Adult/eldercare for adult dependents



How Much Should I Contribute?

You should contribute the amount of money you expect to pay out-of-pocket for eligible expenses for the plan period. Typically, unused funds are forfeited at the end of the plan year. This is the use-it-or-lose-it rule.

LEARN MORE ONLINE!

Visit www.myflexaccount.com to find out more information on your flexible spending accounts.

TRANSIT & PARKING ACCOUNTS

Flexible Benefit allows employees to save real money on something they already pay for: *Their commute to work.*

Commuters can use pre-tax dollars to pay for their commute (up to **\$260/month for transit** and up to **\$260/month for qualified parking**) and save on taxes. Subway, bus, train, ferry, car, or vanpool - They've got you covered. Visit www.myflexaccount.com for more information.



BENEFIT RESOURCES

GLOBAL FIT

Get active with the Global Fit Gym Membership Program! GlobalFit offers discounts at more than 10,000 gyms nationwide. Members also get exclusive savings on home health and fitness products including Zumba, Total Gym, Schwinn, StairMaster and more! Learn more about GlobalFit by calling **800.294.1500** or visiting www.globalfit.com/connerstrong.

HEALTHY LEARN

HealthyLearn covers over a thousand health and wellness topics in a simple, straightforward manner. The data and information is laid out in an easy-to-follow format. Learn more and get started on your path to wellness today by visiting HealthyLearn at:

www.healthylearn.com/connerstrong

Download the HealthyLife Mobile App for access on-the-go!

1. Search your app store for “healthylife mobile”
2. Download and open the app
3. Enter the Conner Strong & Buckelew special access code: **CSB (all caps)**

Please note: you must use the special access code above each time you open the app.

GOOD RX

GoodRx allows you to simply and easily search for retail pharmacies that offer the lowest price for specific medications. Use GoodRx to compare drug prices at local and mail-order pharmacies and discover free coupons and savings tips. Find out how GoodRx can save on your prescription drugs by visiting connerstrong.goodrx.com.



BENEFITS MEMBER ADVOCACY CENTER

The Benefits Member Advocacy Center (Benefits MAC), provided by our benefits consultant, Conner Strong & Buckelew, allows you to speak to a specially trained and licensed Client Service Associate who can assist with benefit claims issues, coverage questions, and enrollment inquiries.

This service is available Monday through Friday, 8:30 am to 5:00 pm (EST) or you can submit a request online 24/7.

To contact the Benefits MAC

call **800.563.9929** or go to

www.connerstrong.com/memberadvocacy

LEGAL NOTICES

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 (including COBRA 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 or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment. When the loss of other coverage is COBRA coverage, then the entire COBRA period must be exhausted in order for the individual to have another special enrollment right under the Plan. Generally, exhaustion means that COBRA coverage ends for a reason other than the failure to pay COBRA premiums or for cause (that is, submission of a fraudulent claim). This means that the entire 18-, 29-, or 36-month COBRA period usually must be completed in order to trigger a special enrollment for loss of other coverage. Coverage will be effective the first of the month following your request for enrollment.

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). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

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 or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption. If you request a change within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption.

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. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

To request special enrollment or obtain more information, contact the Human Resources.

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.

Newborns' and Mothers' Health Protection Act

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).

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.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

Please contact Human Resources for the SBC.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. 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
<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 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.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html>
Phone: 1-877-357-3268



LEGAL NOTICES

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

Healthy Indiana Plan for low-income adults 19-64

Website: <http://www.in.gov/fssa/hip/>

Phone: 1-877-438-4479

All other Medicaid

Website: <https://www.in.gov/medicaid/>

Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: <https://dhs.iowa.gov/ime/members>

Medicaid Phone: 1-800-338-8366

Hawki Website: <http://dhs.iowa.gov/Hawki>

Hawki Phone: 1-800-257-8563

HIPP Website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>

HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>

Phone: 1-800-792-4884

HIPP Phone: 1-800-766-9012

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: KIHIPPPROGRAM@ky.gov

KCHIP Website: <https://kidshealth.ky.gov/Pages/index.aspx>

Phone: 1-877-524-4718

Kentucky Medicaid Website: <https://chfs.ky.gov>

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-

5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: www.mymaineconnection.gob/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: 617-886-8102

Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: <https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>

Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

Phone: 1-573-751-2005

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/>

MontanaHealthcarePrograms/HIPP

Phone: 1-800-694-3084

Email: HSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>

Phone: (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 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/>

dmahs/clients/medicaid/

Medicaid Phone: 609-631-2392

CHIP Website: <http://www.njfamilycare.org/index.html>

CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <https://medicaid.ncdhhs.gov/>

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <https://www.hhs.nd.gov/healthcare>

Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>

Phone: 1-888-365-3742

OREGON – Medicaid

Website: <http://healthcare.oregon.gov/Pages/index.aspx>

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: <https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx>

Phone: 1-800-692-7462

CHIP Website: <https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx>

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 RlIta

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

Medicaid Website: <https://medicaid.utah.gov/>

CHIP Website: <http://health.utah.gov/chip>

Phone: 1-877-543-7669

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>

Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>

Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: <http://mywvhipp.com/> and <https://dhhr.wv.gov/bms/>

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: 800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, 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

ADDITIONAL INFORMATION

- Employee Cost Share Rates
- Disability and Life Insurance Plan
- Insurance Enrollment Benefit Form
- Flexible Spending Account (FSA) Election Form
- Commuter Election (Parking & Transit) Form
- Voluntary Life Insurance Enrollment Form
- Voluntary Long Term Disability Enrollment Form (Hourly Only)
- Beneficiary Designation
- Open Enrollment Fair Information





ABOUT THIS BENEFITS SUMMARY

This Benefits Summary describes the highlights of the Miller & Long Benefits Program in non-technical language. Your specific rights to benefits under this program are governed solely, and in every respect, by the official documents and not the information contained within this Benefits Summary. If there is any discrepancy between the descriptions of the program elements in this Benefits Summary and the official plan documents, the language of the official plan documents shall prevail as accurate. Please refer to the plan-specific documents published by each of the respective carriers for detailed plan information. Eligibility for any benefit plan is determined by applicable plan documents and policies. You should be aware that any and all elements of the Benefits Program may be modified in the future to meet Internal Revenue Service rules or otherwise as determined by Miller & Long.

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