MERIDIAN WASTE

Employee Benefits Guide

PLAN YEAR: 2025

What's Inside

A Message To Our Employees

At Meridian Waste, our employees are our greatest asset. We believe that by offering one of the most comprehensive benefit packages available, we can attract and retain great people! Our benefits package includes core plans that provide a foundation for your good health and well-being.

We realize that our benefits program can be successful only if it is affordable and meets the needs of our employees. As such, we constantly review our benefits and make changes as necessary. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

Your benefits enrollment can be accessed at: **https://www.paycomonline.net/v4/ee/web.php/app/login**

Questions, Problems or Concerns

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. If you require assistance, have your ID number or Social Security Number available and follow these steps:

- For claims assistance call the applicable insurance carrier. Have your ID number, date of service, and provider name available.
- Do you need an ID card? If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.
- If you require further assistance, contact Cindy Greenbaum, SPHR, SHRM-SCP; Director of Meridian Waste Human Resources.

Help Is Here When You Need It

The USI Benefit Resource Center is a team of dedicated professionals available to assist you with any benefit or claim questions you may have. The team will provide you friendly, fast, and reliable service Monday through Friday from 8 a.m. to 5 p.m. Eastern Time.

To speak to a member of your Benefit Resource Center team:

Call: 855-874-0835 | **Email:** BRCSouth@usi.com

Eligibility

Full-time employees with a regular schedule of 30 hours per week are eligible for the benefits described in this guide, unless otherwise stated.

When Benefits Become Effective

Coverage for most benefit plans are effective on the first day of the month following 30 days of employment. Part-time, seasonal, temporary, internship, and contracted employees are not eligible to participate.

Eligible Dependents

Your dependents are eligible to participate in Meridian Waste's benefit plans.
Your eligible dependents include*:

- A spouse to whom you are legally married.
- A domestic partner.
- A dependent child under age 26. Coverage will terminate at the end of the month of the dependent's 26th birthday. Coverage may be extended past the age of 26 for disabled dependents. Dependent children include natural, adopted children, and stepchildren.

Coverage for eligible dependents generally begins on the same day your coverage is effective. Completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

**Additional carrier conditions may apply and may vary by state.*

Newly Hired/Eligible Employees

New hires and newly eligible employees MUST complete enrollment even if choosing to waive coverage in order to provide beneficiary information for your company-paid life insurance.

Pre-Tax Benefits: Section 125

Meridian Waste's benefit plans utilize Section 125. This enables you to elect to pay premiums for health, dental, vision coverage on a pre-tax basis. When you use pretax dollars, you will reduce your taxable income and have fewer taxes taken out of your paycheck. Under Section 125, you can actually have more spendable income than if the same deductions were taken on an after-tax basis.

Pre-tax Note: When you pay for your dependent's benefits on a pre-tax basis you are certifying that the dependent meets the IRS' definition of a dependent. [IRC §§ 152, 21 (b)(1) and 105(b)]. Children/spouses that do not satisfy the IRS' definition will result in a tax liability to you, such as changing that dependent's election to a post-tax election or receiving imputed income on your W-2 for the dependent's coverage that should not have been taken on a pre-tax basis.

For all benefits, you must enroll via Paycom within 30 days from your date of hire

Benefit Changes

The benefit elections you make during open enrollment or as a new hire will remain in effect for the entire plan year. You will not be able to change or revoke your elections once they have been made unless a life event status change occurs.

For purposes of health, dental, and vision coverage, you will be deemed to have a life event status change if:

- your marital status changes through marriage, the death of your spouse, divorce, legal separation, or annulment;
- your number of dependents changes through birth, adoption, placement for adoption, or death of a dependent;
- you, your spouse or dependents terminate or begin employment;
- your dependent is no longer eligible due to attainment of age;
- you, your spouse or dependents experience an increase or reduction in hours of employment (including a switch between part-time and full-time employment; strike or lock-out; commencement of or return from an unpaid leave of absence);
- gain or loss of eligibility under a plan offered by your employer or your spouse's employer;
- a change in residence for you, your spouse or your dependent resulting in a gain or loss of eligibility.

In order to be permitted to make a change of election relating to your health, dental or vision coverage due to a life event status change, the change must result in you, your spouse or dependent gaining or losing eligibility for health, dental or vision coverage under this plan or a plan sponsored by another employer by whom you, your spouse or dependent are employed. The election change must correspond with that gain or loss of eligibility.

You may also be permitted to change your elections for health coverage under the following circumstances:

- a court order requires that your child receive accident or health coverage under this plan or a former spouse's plan;
- you, your spouse or dependent become entitled to Medicare or Medicaid;
- you have a Special Enrollment Right;
- there is a significant change in the cost or coverage for you or your spouse attributable to your spouse's employment.

For purposes of all other benefits under the plan, you will be deemed to have a life event status change if the change is on account of and consistent with a change in status, as determined by the plan administrator, in its discretion, under applicable law and the plan provisions.

You must notify your site supervisor / Human Resources within 30 days from the life event status change in order to make a change in your benefit selections.

Benefit Changes

EVENT	ACTION REQUIRED	RESULTS IS ACTION NOT TAKEN
New Hire	Make elections within 30 days of hire date. Documentation is required.	You and your dependents are not eligible until the next annual Open Enrollment.
Marriage	Your new spouse must be added to your elections within 30 days of the marriage date. A copy of the marriage certificate must be presented.	Your spouse is not eligible until the next annual Open Enrollment period.
Divorce	The former spouse must be removed within 30 days of the divorce. Proof of the divorce will be required. A copy of the divorce decree must be presented.	Benefits are not available for the divorced spouse and will be recouped if paid erroneously.
Birth or adoption of a child	The new dependent must be enrolled in your elections within 30 days of the birth and adoption, even if you already have family coverage. A copy of the birth certificate, footprints, or hospital discharge papers must be presented. Once you receive the child's Social Security Number, be sure to contact the Human Resources Department to update your child's insurance information record.	The new dependent will not be covered on your health insurance until the next annual Open Enrollment period.
Death of a spouse or dependent	Remove the dependent from your elections within 30 days from the date of death. Death certificate must be presented.	You could pay a higher premium than required and you may be overpaying for coverage.
Your spouse gains or loses employment that provides health benefits	Add or drop health benefits from your elections within 30 days of the event date. A letter from the employer or insurance company must be presented.	You need to wait until the next annual Open Enrollment period to make any change.
Loss of coverage with a spouse	Change your elections within 30 days from the loss of coverage. A letter from the employer must be provided.	You will be unable to enroll in the benefits until the next annual Open Enrollment period.
Changing from full-time to part-time employment (without benefits) or from part-time to full-time (with benefits)	Change your elections within 30 days from the employment status change in order to receive COBRA information or to enroll in benefits as a full-time employee. Documentation from the employer must be provided.	Benefits may not be available to you or your dependents if you wait to enroll in COBRA. Full-time employees will have to wait until the annual Open Enrollment period.

If you Experience a Life Event Status Change

You must update your elections within 30 days of your life event status change or you will not be able to make changes until the next annual open enrollment. If adding or removing dependents, you are required to submit specific documents to the Human Resources Department. The change will be inactive until proper documentation is received and approved. For assistance processing life event status changes, you can contact Cindy Greenbaum, SPHR, SHRM-SCP; Director of Human Resources at 1-770-691-6370 or by emailing cgreenbaum@meridianwaste.com.

Medical Coverage

Meridian Waste is proud to offer you a choice between two different medical plans. Coverage under both plans includes comprehensive medical care and prescription drug coverage. The plans also offer many resources and tools to help you maintain a healthy lifestyle. Below is a brief description of each plan.

Cigna OAP Option I
80%, $3,000 Deductible

Cigna HDHP OAP Option II
100%, $6,000 Deductible

Meridian Waste is proud to offer you a choice between two different medical plans. Coverage under both plans includes comprehensive medical care and prescription drug coverage. The plans also offer many resources and tools to help you maintain a healthy lifestyle. Below is a brief description of each plan.

Both Cigna Open Access Plus (OAP) Plans give you and your family access to the OAP network of preferred care providers. As a member of either plan, you can use the doctors and hospitals within the network or go outside of the network for care. The plans do not require members to designate a "primary care physician" to coordinate care or require referrals to seek care from specialists.

Meeting Your Deductible: The deductible is an agreed dollar amount paid by you (or combined amount by family members) before the health insurance plan will begin to pay incurred health care costs. Related health expenses are added together as they occur until they add up to the agreed deductible level.

After Your Deductible Has Been Met: When you have met your deductible, you'll move into the "coinsurance / copay" stage and the doctor or facility sends the claim directly to the insurance company. The insurance company will pay the doctor or facility directly. You will only be responsible for any coinsurance / copay, if applicable.

In-Network: This level of benefits applies when you use a physician, specialist or other provider who is a member of the Cigna OAP network. By utilizing in-network providers, you will pay lower deductibles and coinsurance than you will using out-of-network providers. Please note that there is no penalty for seeking specialist care without a referral, thus providing more freedom and easier access to care.

Out-of-Network: This level of benefits applies when you use a provider who is not a member of the Cigna OAP network. You will be covered, but you will pay higher coinsurance than you will using In-Network providers. In addition, you are responsible for any amounts incurred in excess of the "covered charges." Additionally, out-of-network providers may require you to pay for services at the time of service and you will have to file a claim with Cigna in order to be reimbursed.

We encourage you to download the Cigna Mobile App for locating providers, monitoring the status of claims, and for viewing your Member ID Card. The app is free and available for iOS and Android.

Medical Coverage

Build a Strong Relationship with Your Primary Care Physician

Most doctors went into the practice of medicine so that they could build strong emotional bonds with patients and guide them through health challenges.

Here are 3 tips to building a strong relationship with a new primary care physician, or improving the bond with your current one:

1. **Know what's important to you in a physician.**
   If you're looking for a new doctor, be sure this is someone with whom you will have good interpersonal chemistry, that they're committed to your well-being, and that their office is well organized.
2. **Get your doctor familiar with your health history.**
   Help your doctors to get to know you better by collecting your medical records, writing down your family's health history, and sharing this information with every new physician you meet.
3. **Ask the right questions to build rapport and get on the road to better health.**
   To maximize the time you have together, write down your health questions for your physician beforehand.

Medical Plan Comparison

	Cigna OAP Option I 80%, $3,000 Deductible In-Network, You Pay:	Cigna HDHP OAP Option II 100%, $6,000 Deductible In-Network, You Pay:
Deductible Individual/Family	**$3,000/$9,000**	**$6,000/$12,000**
Out-of-Pocket Maximum Individual/Family	$6,000/$12,000	$6,000/$12,000
Preventive Services Well-Child Care Adult Physical Examination Breast Cancer Screening Pap Test	No charge	No charge
Office Visits Primary Care Physician Specialist Virtual Visits Convenience Care Clinic	$25 copay $75 copay $25 copay	Deductible, then no charge Deductible, then no charge Deductible, then no charge
Inpatient Care Inpatient Facility Services Inpatient Physician Services Skilled Nursing Facility (60 days/year)	Deductible, then 20% Deductible, then 20% Deductible, then 20%	Deductible, then no charge Deductible, then no charge Deductible, then no charge
Outpatient Care Outpatient Facility Services Outpatient Physician Services	Deductible, then 20% Deductible, then 20%	Deductible, then no charge Deductible, then no charge
Emergency Services Emergency Room Urgent Care Ambulance	Deductible, then $350 copay, then 20% $25 copay Deductible, then 20%	Deductible, then no charge Deductible, then no charge Deductible, then no charge
Laboratory Services	Deductible, then 20%	Deductible, then no charge
Radiology Services	Deductible, then 20%	Deductible, then no charge
Outpatient Therapy Services Physical Therapy (20 visits) Occupational Therapies (30 visits/year) Chiropractic Care (20 visits)	$75 copay $75 copay $75 copay	Deductible, then no charge Deductible, then no charge Deductible, then no charge
Durable Medical Equipment	Deductible, then 20%	Deductible, then no charge
	Out-of-Network, You Pay:	**Out-of-Network, You Pay:**
Deductible Individual/Family	$5,000/$10,000	$12,000/$24,000
Out-of-Pocket Maximum Individual/Family	$10,000/$20,000	$12,000/$24,000
Coinsurance for Most Services	Deductible, then 40%	Deductible, then 0%

**This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.*

Prescription Coverage

Your prescription drug benefit is part of your medical plan. The prescription drug formulary generally lists many drugs and ranks them in groups described as tiers. Copayments and/or coinsurance is determined by the tier in which the health plan will pay for, and prefer you use.

To find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to www.cigna.com or by calling Cigna at 1-866-494-2111.

Medicare Part D

The prescription drug benefit is creditable coverage. Medicare- eligible participants need not enroll in a separate Medicare D drug plan.

Save Money with Generic Drugs

Generic drugs are made with the same active ingredients and produce the same effects in the body as their brand-name equivalents. That's because they're held to the same federal standards for safety and performance as the brand names. Because they're not branded, generics can sell for 30 percent to 80 percent less than their brand-name equivalents.

	Cigna OAP Option 1 80%, $3,000 Deductible	Cigna HDHP OAP Option 2 100%, $6,000 Deductible
Retail (per 30-day supply)		
Generic Drugs	$15 copay	$10 copay after deductible
Preferred Brand Drugs	$40 copay	$30 copay after deductible
Non-Preferred Brand Drugs	$75 copay	$60 copay after deductible
Retail and Home Delivery (per 30-day supply)		
Specialty Drugs	$200 copy	$200 copay after deductible
Retail and Home Delivery (per 90-day supply)		
Generic Drugs	$38 copay	$30 copay after deductible
Preferred Brand Drugs	$100 copay	$90 copay after deductible
Non-Preferred Brand Drugs	$188 copay	$180 copay after deductible

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Cigna 90 Now

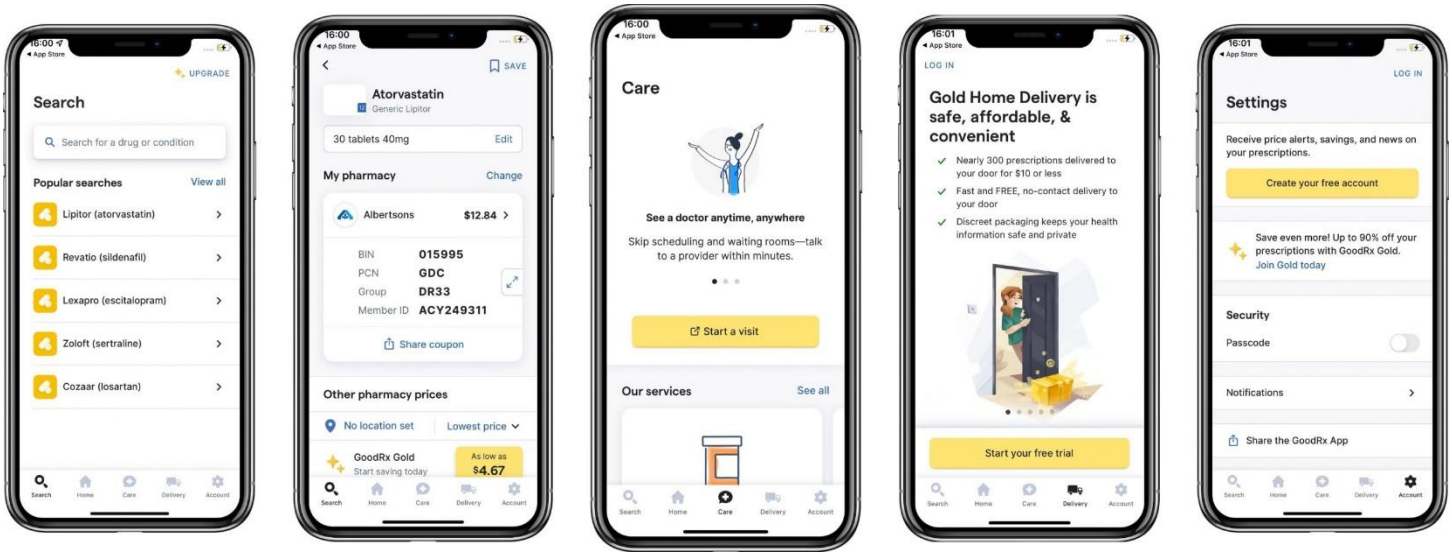
Save time and money by filling maintenance drugs through Cigna 90 Now. Members who are on long-term medications for chronic conditions such as diabetes, high cholesterol, high blood pressure, depression or asthma can benefit from using Cigna 90 Now. By utilizing Cigna 90 Now, you can receive a 90-day supply of medication at a discounted price. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.

Prescription Coverage

GoodRx Mobile App

Regardless of which plan you decide to enroll in, we encourage you to download and use the GoodRx Mobile App to help you save on your prescription drug costs. Prices for prescription drugs vary widely between pharmacies. The cost of a prescription may differ by more than $100 between two pharmacies across the street from each other.

GoodRx doesn't sell the medications, they will tell you where you can get the best deal on them. GoodRx will show you prices, coupons, discounts and savings tips for your prescription at pharmacies near you.



Health Savings Account (HSA)

Fidelity Health Savings Account

A tax-advantaged way to pay for qualified medical expenses

A Health Savings Account (HSA) can be an easy and smart way to save money to pay for qualified medical expenses[1] for you and your dependents. With its triple tax advantages,[2] easy access to funds, and future growth potential, it's a unique savings vehicle that provides benefits today and in the future.

It's no secret that health care costs have been skyrocketing for many years and that the rapid rate of increase is affecting us all. It's estimated that an individual retiring today at age 65 will need $157,500 to cover health care expenses in retirement.[3] That means saving for health care should be an important part of retirement planning.

There is an approach that can help you better plan for and meet these rising costs — enrollment in an HSA-eligible health plan (also known as a High-Deductible Health Plan [HDHP]) and an HSA. This combination can potentially save you money on health care while giving you more control over how your medical dollars are spent.

To help you better understand HSA-eligible health plans, HSAs, and how the two work together, here are answers to some commonly asked questions to help you get started.

What is an HSA-eligible health plan?

An HSA-eligible health plan is an HDHP that satisfies certain IRS requirements with respect to deductibles and out-of-pocket expenses. You generally pay more up front for medical expenses before the plan begins to pay for covered services. In return, you will generally pay less in premiums than in other medical plans and general preventative care services are fully covered. Enrollment in an HSA-eligible health plan is one of the requirements to be eligible to establish an HSA.

What is an HSA?

An HSA is an individual account used in conjunction with an HSA-eligible health plan to cover out-of-pocket qualified medical expenses on a tax-advantaged basis. Your HSA belongs entirely to you and can be used to pay for both current and future qualified medical expenses for you and your eligible dependents. You can contribute to your account, withdraw contributions to pay for current qualified medical expenses, and potentially grow your account on a tax-free[2] basis by investing your savings in a wide array of investment options.

Why should I consider an HSA?

If you have the opportunity to enroll in an HSA-eligible health plan with an HSA, you may want to take a closer look. This combination may offer some significant tax and savings advantages over traditional health care plan options — no matter if you're a low, medium, or high user of health care services.

Control. You determine how much to contribute (up to your maximum annual contribution limit per IRS rules), when and how to invest your contributions, and whether to take an HSA distribution to pay for current qualified medical expenses, or let your contributions stay invested for future growth potential.

Four Things to Know about a Health Savings Account (HSA)

Have you been hearing the buzz, but you're still not sure what an HSA is or how it works? An HSA pairs with an HSA-eligible health plan[1] to create a unique approach to health care—one that can play a valuable role in your overall health and financial wellness. Here are four key things to know about an HSA.

1 It's YOURS

An HSA is an individual account you own that can be used to pay for out-of-pocket qualified medical expenses that your health plan doesn't cover. You decide how much to contribute,[2] when to tap into your HSA, and how to invest your savings. You can use your HSA to pay for qualified medical expenses incurred by you, your spouse, and your dependents—including health plan deductibles and coinsurance, most medical care and your services, dental and vision care, and prescription drugs. The entire balance is yours to keep—even if you change jobs, change medical coverage, or retire.

2 It's EASY TO USE

You can save money in your HSA on a pretax basis through payroll deductions or by making after-tax contributions by transferring money online from an outside bank account. When you decide to use your HSA to pay for a qualified medical expense, you have a variety of options to access your funds, including using an HSA checkbook, an online bill paying service, or the direct debit capability, to name a few. You can also access an online portal, which provides an easy way to track, pay, and manage claims. HSAs have a convenient reimbursement feature, too. If you decide to pay out of pocket for a qualified medical expense, you can later reimburse yourself from your HSA at any time without penalty—weeks or even years in the future—provided you have receipts that total the appropriate amount.

3 It's FLEXIBLE

Spend your HSA today or save it for tomorrow—it's up to you. Because your balance automatically carries over from year to year, you don't have to worry about losing money that you haven't spent. If you're paying for current qualified medical expenses, you can save money in your HSA in cash for easy access. Any savings not needed for current qualified medical expenses can be invested in a wide variety of investment options—including mutual funds, stocks, bonds, and CDs—to potentially grow your balance for future qualified medical expenses, such as those in retirement. Once you reach age 65, you can use your HSA for any reason—just pay normal income taxes on any money used for a nonqualified medical expense.[3]

4 It's A SMART WAY TO SAVE MONEY

Because an HSA works together with an HSA-eligible health plan, you can potentially save money on health insurance premiums and reduce your taxable income at the same time. First, an HSA-eligible health plan generally has a much lower monthly premium than a traditional health care plan. Second, an HSA offers three-way tax savings you can't find elsewhere, which can help you save money. Pretax contributions made through payroll deduction lower your taxable income, and after-tax contributions are tax deductible. Also, you don't pay federal taxes[4] on any investment earnings or on the money you use to pay for qualified medical expenses. Over time, those tax savings could add up.

Want to know more about the Fidelity HSA®? Visit Fidelity.com/healthsavingsaccount or call 800-544-3716 or your plan's toll-free number.

Voluntary Dental Coverage

Sun Life
Life's brighter under the sun

Sun Life Dental PPO

The Sun Life Dental PPO plan offers flexibility to see the provider of your choice each time you seek dental care. You can find a network dentist online at www.sunlife.com or by calling 1-800-442-7742.

	Dental PPO	
	In-Network, You Pay:	**Out-of-Network, You Pay:***
Calendar Year Deductible Per Individual/Per Family	**$50/$150**	**$50/$150**
Preventative Care Cleanings, Fluoride, Oral Exams, Sealants, X-rays	No charge, deductible waived	No charge*, deductible waived
Basic Care Anesthesia, Fillings, Simple Extractions	Deductible, then 20%	Deductible, then 50%*
Major Care Bridges, Dentures, Implants, Inlays, Onlays, Single Crowns, Root Canal	Deductible, then 50%	Deductible, then 50%*
Orthodontia Coverage for Eligible Children Only	Deductible, then 50%	Deductible, then 50%*
Annual Maximum Benefit	$1,000	$1,000

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Weekly Plan Cost	**Dental PPO**
Employee Only	$4.13
Employee + Spouse	$8.26
Employee + Child(ren)	$10.30
Family	$15.25

Preventive Rewards

Sun Life PPO dental plans with our Preventive Rewards option rewards employees for getting annual preventive care. Dental members can get additional maximum dollars added to their benefits based on their paid claims for preventive services. This promotes preventive care while providing additional maximum dollars for future years when they might need additional services. The additional maximum dollars can be spent on any covered services, not just preventive services.

How does the Preventive Rewards work?

Let's say you have a $1,000 annual maximum *plus Preventive Rewards* on your plan. When a dental member has paid claims for preventive services in a year, they can rollover the amount of those paid claims, up to $1,000 for future years. They can get additional rewards each year until they hit $1,000. This rewards dental members for getting preventive treatments while increasing their annual maximum dollars for future treatments.

Voluntary Vision Coverage

Sun Life
Life's brighter under the sun

Sun Life Vision Plan

As a Sun Life VSP Vision care member, you'll receive access to great eyes doctors, quality eyewear and lower out-of-pocket costs. To find an in-network provider, visit www.vsp.com or call 1-800-877-7195. At your appointment, tell them you have coverage with Sun Life VSP Vision.

	Vision Plan	
Your Network is	**VSP Vision**	
Copay Exams Materials (waived for elective contact lenses)	 $10 $25	
	You pay (after applicable copay)	
	In-Network	**Out-of-Network**
Eye Exams	$10 copay	Up to $52
Lenses Single/Bifocal/Trifocal/Lenticular	 $25 copay	Up to $55/$75/$95/$125
Frames	$130 allowance, and 20% of balance	Up to $57
Contact Lenses Elective Medically Necessary	 Up to $60 allowance. $130 allowance	 Up to $105
Glasses (Additional pair of frames and lenses)	20% discount from the same VSP provider	No discounts
Laser Correction Surgery Discount	Average of 15% off the regular price or 5% off promotional price	No discounts
	Service Frequencies	
Exams	1 every 12 months	
Lenses (for glasses or contact lenses)	1 every 12 months	
Frames	1 every 24 months	

**This summary is for informational purposes only. For specific benefit information, please refer to the applicable plan summary or contract.*

Weekly Plan Cost	Vision Plan
Employee Only	$1.49
Employee + Spouse	$2.51
Employee + Child(ren)	$2.56
Family	$4.04

Basic Life and AD&D Insurance

Sun Life
Life's brighter under the sun

Basic Life Insurance

Life insurance provides financial protection for your family in the event of your passing. Meridian Waste offers all employees life and accidental death and dismemberment insurance through Sun Life. Meridian Waste covers the full cost of this benefit.

Basic Life Benefit Amount: $20,000

AD&D Benefit Amount: Equal to Life amount

Your benefit amount will reduce by 35% at age 65, 60% at age 70, 75% at age 75, and 85% at age 80. Benefits terminate upon retirement.

PLAN COST: 100% EMPLOYER PAID

Sun Life

Life's brighter under the sun

Voluntary Life and AD&D Insurance

Increase Your Coverage

You may elect to increase your life insurance coverage for yourself, your spouse and your dependent children – all at an affordable group rate provided by Sun Life.

This coverage comes in the following increments:

Employee Voluntary Life/AD&D Insurance

Benefit Amount: increments of $10,000 up to $150,000

Guarantee Issue*: Age <65: $100,000 Age 65-69: $50,000 Age 70+: $10,000

**Evidence of Insurability required for amounts over Guarantee Issue. If you do not elect voluntary life when first eligible, you and your dependents will have to complete the Evidence of Insurability form, regardless of the amount of life insurance chosen.*

Spousal Voluntary Life/AD&D Insurance

Benefit Amount: increments of $5,000 up to $75,000; can not exceed 50% of the Employee Benefit Amount

Guarantee Issue*: Age <65: $50,000 Age 65-69: $10,000 Age 70: Coverage ends.

**Evidence of Insurability required for amounts over Guarantee Issue.*

Dependent Child Voluntary Life/AD&D Insurance

Benefit Amount: increments of $1,000 up to $10,000; can not exceed 50% of the Employee Benefit Amount

EMPLOYEE-PAID; GROUP RATE BASED ON AGE

Portability Options for Basic & Voluntary Life

Portability is available when an Insured Person's employment terminates for a reason other than sickness or injury or retirement at the Social Security Normal Retirement Age (SSNRA). The Insured Person's coverage must be in force for at least 12 months in a row just prior to the date employment ends.

This person has the option to continue all or part of his or her insurance enforce when employment ends without Evidence of Insurability. To continue insurance, application and the first premium payment must be made within the time period specified in the policy. Coverage can continue until the earlier of the date the master policy terminates or up to 36 Months.

For information on Portability, please contact the Meridian Waste Human Resources Department.

Sun Life

Life's brighter under the sun

Short-Term Disability

To ensure your income will continue if you are unable to work due to a disability that extends for more than 7 consecutive days, Meridian Waste provides short-term disability (STD) through Sun Life. Benefits are payable for a non-occupational injury or illness that keep you from performing the normal duties of your job. If a medical condition is job-related, it is considered Workers' Compensation rather than STD.

Benefits Start After: 7 days

Benefit Amount: 60% of basic earnings up to $1,000 / week

Benefit Duration: 26 weeks

Short-Term Disability Rates	
Age Band	**Weekly Rates**
Under age 25	$.129
25-29	$.129
30-34	$.171
35-39	$.171
40-44	$.220
45-49	$.261
50-54	$.358
55-59	$.427
60-64	$.498
65-69	$.498
70+	$.498

Long-Term Disability

Long-Term Disability (LTD) insurance helps replace a portion of your income if you are disabled for an extended period of time. Eligibility for long-term benefits are generally defined as, due to sickness or accidental injury which you are receiving appropriate care and treatment; are complying with your treatment requirements and unable to earn more than 80% of your pre-disability earnings.

Benefits Start After: 180 days

Benefit Amount: 60% of basic earnings up to $10,000 / month

Benefit Duration: 5 years to age 70 for Class 1 or SSNRA for Class 2

Pre-Existing Condition Limitations

The carrier will not pay benefits for any period of Disability caused or contributed to by, or resulting from, a Pre-existing Condition. A "Pre-existing Condition" means any Injury or Sickness for which you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before your most recent effective date of insurance.

The Pre-existing Condition Limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of Disability that begins after you are covered for at least 12 months after your most recent effective date of insurance, or the effective date of any added or increased benefits.

Long-Term Disability Rates	
Age Band	**Weekly Rates**
Under age 25	$.044
25-29	$.044
30-34	$.062
35-39	$.088
40-44	$.118
45-49	$.187
50-54	$.270
55-59	$.392
60-64	$.430
65-69	$.430
70+	$.430

Sun Life
Life's brighter under the sun

Voluntary Benefits

The following Voluntary Benefits can complement existing medical coverage and help fill financial gaps caused by out-of-pocket expenses such as deductibles, co-payments, and non-covered medical services. Benefits are paid regardless of what is covered by medical insurance. Payments are made directly to you, to spend as you choose.

All four plans are portable meaning you can continue coverage if you leave the company.

Accident Insurance

Accident Insurance is designed to help covered individuals meet the out-of- pocket expenses and extra bills that can follow an accidental injury, whether minor or catastrophic. Lump sum benefits are paid directly to you based on the amount of coverage listed in the schedule of benefits. The coverage is guaranteed issue, so no health questions are required.

Coverage for accidental injury, minor or catastrophic.

Below are some examples of covered accidents and the Benefit Amount (BA) that you will be paid:

Basic Accidental Death and AD&D:
Employee: $25,000
Spouse: $25,000
Child: $12,500

Catastrophic Loss:
Quadriplegia: $25,000
Loss of speech or sight: $7,500
Hemiplegia: $10,000
Paraplegia: $12,500

Fractures:	**Open**	**Closed**
Hip or Thigh	$8,000	$4,000
Skull Depression:	$10,000	$5,000
Leg or Pelvis:	$5,000	$2,500
Multiple Ribs:	$1,000	$500

Coma: $10,000

Concussion: $100

Air Ambulance: $1,000

Ambulance: $200

Hospital Admission: $1,000

Laceration: Schedule up to $400

Open Surgery: $1,250

Burns: Schedule up to $15,000

Diagnostic Exam: $200

Wellness Benefit:
$75 per year for routine wellness screening

Accident Insurance	
Weekly Plan Cost	
Employee Only	$3.15
Employee + Spouse	$5.05
Employee + Child(ren)	$6.11
Family	$8.01

Voluntary Benefits

Sun Life
Life's brighter under the sun

Critical Illness Insurance

Critical Illness Insurance is designed to help you offset the financial effects of a catastrophic illness with a lump sum benefit if you are diagnosed with a covered critical illness. The benefit is based on the amount of coverage in effect on the date of diagnosis or the date treatment is received according to the terms and provisions of the policy.

Coverage if diagnosed with a covered critical illness.

Employees and Spouses can elect coverage in $10,000 increments up to $40,000. (Spousal coverage cannot exceed 100% of the employee election. Dependent child(ren) will be offered coverage in increments of $5000 up to $20,000; not to exceed 50% of the employee election.

Below are some examples of covered critical illnesses and the Benefit Amount (BA) that you will be paid:

Invasive Cancer:
First Occurrence: 100% of BA
Reoccurrence: 100% of BA

Heart Attack:
First Occurrence: 100% of BA
Reoccurrence: 100% of BA

Stroke:
First Occurrence: 100% of BA
Reoccurrence: 100% of BA

Wellness Benefit:
$75 per year for routine wellness screening

Hospital Indemnity Insurance

Hospital Indemnity insurance is designed to help provide financial protection by paying a benefit due to a hospitalization and, in some cases, for treatment received for an accident or sickness, even if that treatment occurs outside the hospital. You may use the benefit to meet the out-of-pocket expenses and extra bills that occur.

Coverage if you are hospitalized, and for some treatments.

Below are some examples of covered incidents and the Benefit Amount that you will be paid:

Hospital/ICU Admission:
First Day - $1,000 for 1 day.

Hospital/ICU Confinement:
$100 per day, limited to 15 days.

Health Screenings:
$75 per day, limited to 1 day per insured per benefit year

** For a full list of coverages for each plan and specific benefit information, please refer to the applicable insurance contract.*

Voluntary Benefits

Sun Life
Life's brighter under the sun

Critical Illness & Hospital Insurance Rates

Critical Illness Insurance – Employee Non-Tobacco						
Coverage Amount	**<30**	**30-39**	**40-49**	**50-59**	**60-69**	**70+**
$10,000	$1.62	$2.40	$4.48	$7.85	$10.89	$18.53
$20,000	$3.23	$4.80	$8.95	$15.69	$21.78	$37.06
$30,000	$4.85	$7.20	$13.43	$23.54	$32.68	$55.59
$40,000	$6.46	$9.60	$17.91	$31.38	$43.57	$74.12

Critical Illness Insurance – Employee Tobacco						
Coverage Amount	**<30**	**30-39**	**40-49**	**50-59**	**60-69**	**70+**
$10,000	$1.73	$2.93	$6.69	$13.87	$21.28	$34.66
$20,000	$3.46	$5.86	$13.38	$27.74	$42.55	$69.32
$30,000	$5.19	$8.79	$20.08	$41.61	$63.83	$103.98
$40,000	$6.92	$11.72	$26.77	$55.48	$85.11	$138.65

Critical Illness Insurance – Spouse Non-Tobacco						
Coverage Amount	**<30**	**30-39**	**40-49**	**50-59**	**60-69**	**70+**
$10,000	$1.62	$2.40	$4.48	$7.85	$10.89	$18.53
$20,000	$3.23	$4.80	$8.95	$15.69	$21.78	$37.06
$30,000	$4.85	$7.20	$13.43	$23.54	$32.68	$55.59
$40,000	$6.46	$9.60	$17.91	$31.38	$43.57	$74.12

Critical Illness Insurance – Spouse Tobacco						
Coverage Amount	**<30**	**30-39**	**40-49**	**50-59**	**60-69**	**70+**
$10,000	$1.73	$2.93	$6.69	$13.87	$21.28	$34.66
$20,000	$3.46	$5.86	$13.38	$27.74	$42.55	$69.32
$30,000	$5.19	$8.79	$20.08	$41.61	$63.83	$103.98
$40,000	$6.92	$11.72	$26.77	$55.48	$85.11	$138.65

Critical Illness Rates - Child

Critical Illness	
Coverage Amounts	**Weekly Cost**
$5,000	$0.10
$10,000	$0.21
$15,000	$0.31
$20,000	$0.42

Hospital Insurance Rates

Hospital Indemnity Insurance	
Weekly Plan Cost	
Employee Only	$3.76
Employee + Spouse	$8.81
Employee + Child(ren)	$6.51
Family	$11.56

Voluntary Benefits

Cancer Insurance

A cancer diagnosis may have crossed your mind over the years. Or you may have a family history. Recovering from cancer would be your main focus. Cancer also has a financial impact that can be hard to recover from. Cancer insurance pays you cash benefits for a variety of the ways your cancer is treated.

Coverage if diagnosed with Cancer

Coverage is provided for a covered person who is diagnosed with cancer after the effective date of insurance. Coverage is available for you and your family. An eligible child is defined as your child from birth to age 26. Benefits are paid directly to you.

Below are some examples of covered services that you will be paid for:

Second Surgical Opinion: $200

Hospital Confinement: $400 daily (limited to 90 days)

Ambulance:
Air: $2,000
Ground: $250

Prothesis:
Surgically implanted: $3,000
Other: $300

Surgery and Anesthesia:
Surgical: $150 to $5,500
Anesthesia: $50 to $1,815

Radiation and Chemotherapy:
Injected Cytotoxic Medications: $1,000 weekly
Pump Dispensed Cytotoxic Medications: $1,000 (first prescription)
Oral Cytotoxic Medications: $500 per prescription
External Radiation Therapy: $600 weekly

Additional benefits if you enroll in Level 2:

First occurrence internal cancer: $5,000

Medical Imaging: $100

Home Health Care: $50 per visit

Outpatient Hospital Surgical: $250 daily

Transportation: $500

Lodging: $100 daily

Bone Marrow or Stem Cell Transplant:
Bone Marrow: $10,000
Donor: $1,500
Stem Cell: $2,500

Cancer Insurance	
Weekly Plan Cost	
Employee Only	$7.76
Employee + Spouse	$12.74
Employee + Child(ren)	$8.81
Family	$13.79

Norton Lifelock – Identity Theft

norton LifeLock Benefit Solutions

Are you worried about the health of your digital life?

We help protect your personal information and finances.

Your identity is valuable, regardless of what you own or how much money you make. We help protect your finances by monitoring your personal information for possible identity theft and financial fraud.

We provide protection when you connect online.

Everybody is scrolling. How do you know if the ad you see online could take you to a harmful site? We block thousands of digital threats every minute - even before they can infect your computers, phones,
and tablets.

We're here to help when you need it.

If your identity got stolen, would you know who to call? Or where to turn for support? Our U.S.-based Restoration Specialists, will personally handle your identity theft case until it's resolved.

Has your personal info been exposed in a data breach?

Try our free **Threat Detector** tool to uncover potential threats to your identity.

Premier Plan

$9.99 – Employee Only

$18.98- Employee + Family

*Monthly rates

Enroll Now!

Benefit Plans are **60% less** than the retail equivalent.

EAP / Work/Life Services

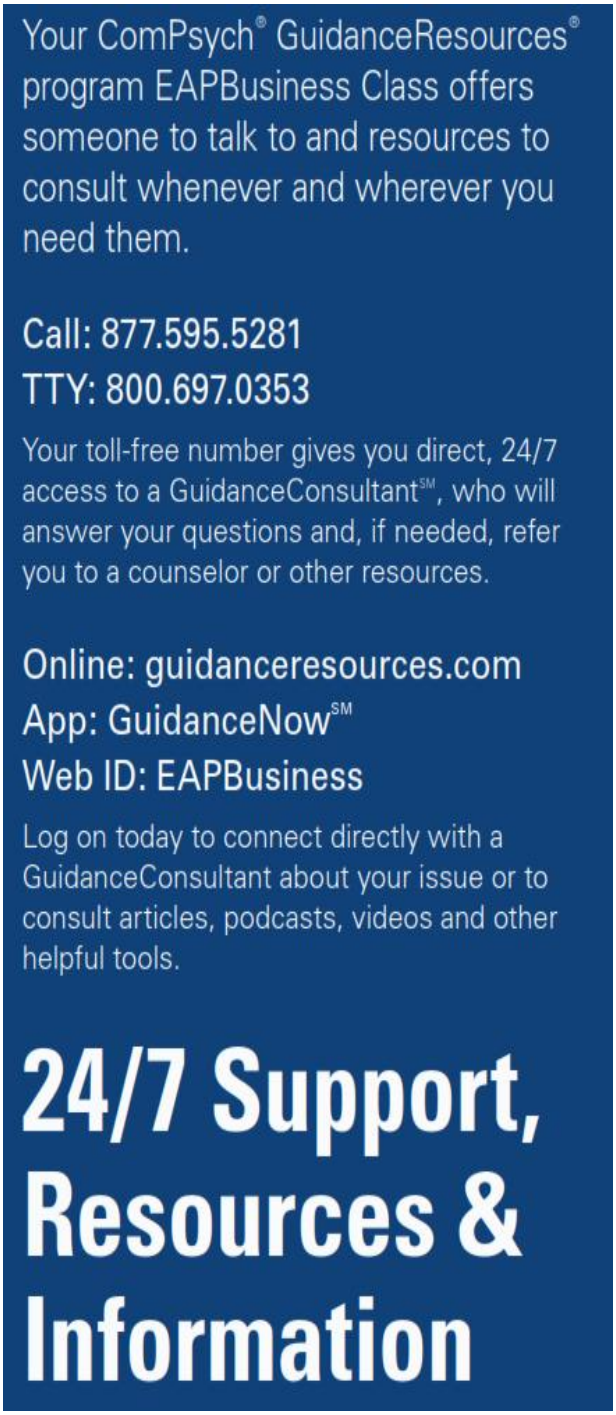
Sun Life
Life's brighter under the sun

Employee Assistance Program (EAP)

Through the EAP by Design program, employees have access to many helpful services that address personal life challenges and improve workplace productivity and performance. Sunlife is proud to offer our three-tiered Employee Assistance Program (EAP) in partnership with ComPsych Corporation.

Services provided:

- **EAP**: Three face-to-face visits per occurrence with experienced clinicians to help address any personal concerns.
- **Legal Resources**: One initial consultation with a local attorney, at no charge, plus unlimited phone access to ComPsych legal professionals and discounts on additional services.
- **Financial Resources**: Unlimited phone access to financial professionals for information regarding personal finance and related issues including one face-to-face visit (up to 1 hour) with a local financial professional and access to an online will preparation tool.
- **Work/Life Resources**: Information and referrals on child care, elder care, adoption, relocation, and other personal convenience matters.
- **ParentGuidance**: Unlimited phone access for the new parent either about to go or already on maternity leave; support for parents; and return-to-work preparation for the entire family.
- **GuidanceResource Online**: Extensive content regarding personal or family concerns; helpful planning tools; discount programs; and more.
- **Health Risk Assessment**: Online access to health risk assessment survey and a variety of health management tool and information.
- **Direct-to-Customer Reports**: Conditional utilization reports that help with trending, tracking, and identifying employee interest areas.



401(k) Retirement Account

The Meridian Waste 401(k) Retirement Savings Plan offers a convenient way to save for your future through payroll deductions.

Eligibility

You are eligible to participate in the plan on the first day of the month following 1 month of employment with Meridian Waste.

Meridian Waste will match 100% of the first 4% of your contributions to the plan. You may change your contribution at any time online at www.401k.com or you may call 1-800-835-5097.

Employee Contributions

Contributions from your pay are made on a pre-tax basis from 1% to 86% of your compensation -- up to the IRS annual limit. If you are 50 years of age or older (or if you will reach age 50 by the end of the year), you may make a catch-up contribution in addition to the normal IRS annual limit.

Vesting

You are always 100% vested in your contributions and Meridian Waste's contributions.

For More Information

For additional details about the 401(k) Retirement Savings Plan or to enroll or change your contribution rates or investment elections, please visit www.401k.com or call 1-800-835-5097.

Additional Features

- A broad range of investment options. When you decide how to invest your account balance, spreading your savings among different investments can help smooth the ups and downs of market cycles and reduce risk. In deciding how to allocate the investment of your account balance, keep in mind that some of the plan's investment options, known as "target date funds," contain an asset allocation strategy within the investment option itself.
- Safe harbor contributions from Meridian Waste. There is no vesting schedule for the employer match under this plan. You are always vested in Meridian's match of the first 4% of your contributions to the plan
- An account you can take with you. Should you leave the company, your balance is yours to take with you.

This hypothetical illustration assumes pre-tax contributions made at the beginning of each month and an annual effective rate of return of 8% and reinvestment of earnings.

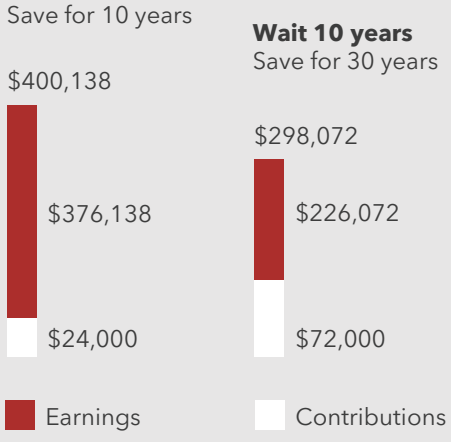
**Start now assumes the contributions are invested for 40 years;*

***Wait 10 years assumes contributions are invested for 30 years. Results are for illustrative purposes only and are not meant to represent the past or future performance of any specific investment vehicle.*

Starting Earlier Can Pay Off

It's important to save enough for your future, and it's also important to understand the concept of compounded returns. The chart shows how starting earlier puts compounding to work for you over time.

Save $200 a month:



Glossary of Terms

This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal: A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. (Jane pays 20%, her plan pays 80%.)

Complications of Pregnancy: Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency cesarean section aren't complications of pregnancy.

Co-payment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. (Jane pays 100%, her plan pays 0%.)

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. Emergency Medical Transportation Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services received in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Health care services that your health insurance or plan doesn't pay for or cover.

Grievance: A complaint that you communicate to your health insurer or plan.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Glossary of Terms

Health Insurance: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care: Health care services a person receives at home.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment: A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non- preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-Network Co- insurance: The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-Network Co-payment: A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network copayments.

Out-of-Pocket Limit: The most you pay during policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit. (Jane pays 0%, her plan pays 100%.)

Physician Services: Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan: A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Glossary of Terms

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium: The amount that must be paid for your health insurance or plan. You and or your employer usually pay it yearly.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that by law require a prescription.

Primary Care Physician: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Benefit Resource Center (BRC)

Access All Of Your Benefits Insurance Details While On The Go!

The Benefit Resource Center (BRC) is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals, and their primary responsibility is to assist you.

The specialists in the Benefit Resource Center are available Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time via phone 855-874-0835 or via email BRCSouth@usi.com. If you need assistance outside of regular business hours, please leave a message and one of the Benefit Specialists will promptly return your call or email message by the end of the following business day.

Call The Benefit Resource Center ("BRC") We're Here To Help!

We speak insurance. Our Benefits Specialists can help you with:

- Deciding which plan is the best for you
- Benefit plan & policy questions
- Eligibility & claim problems with carriers
- Information about claim appeals & process
- Allowable family status election changes
- Transition of care when changing carriers
- Claim escalation, appeal & resolution

Benefit Resource Center (BRC)

BRCSouth@usi.com

Toll Free: 855-874-0835

Monday – Friday | 8:00am to 5:00pm EST

MyBenefits2GO

Free Mobile Benefits App

The MyBenefits2GO app gives you on-the-go access to Meridian Waste's benefit and insurance policy details, HR contact information and more!

The mobile benefits app provides a quick and simple way for you and your enrolled dependents to access benefit summaries and other important information about our group plans. The app also offers the ability to take photos of ID cards to store on the phone, as well as a way to easily locate carrier and HR contact information—all in one place—24/7 and on the go. The MyBenefits2GO app is free and available for iPhone and Android platforms. App benefits include:

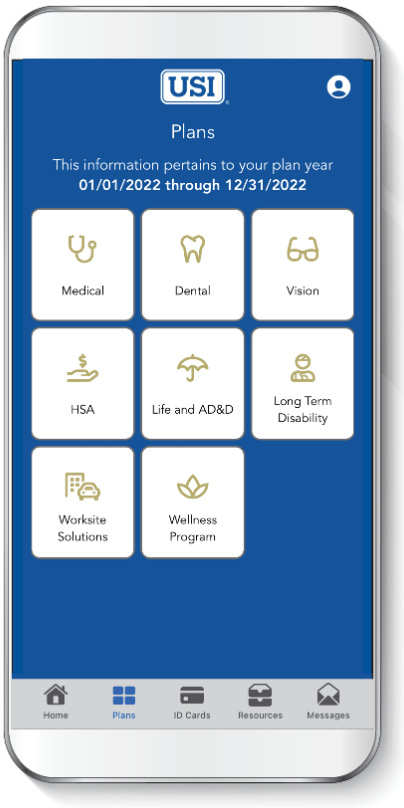
Staying Organized
The app gives you access to benefit plan information and ID cards—all in one place.

Keeping Up-to-Date
The app automatically connects you with the most updated plan information.

Lightening Wallets
The app allows you to store and share images of your ID cards. Images are stored on the phone itself; no personal health information is transmitted or saved.

Getting In Touch
The app provides you with a single location to find contact information for the Human Resources team and the Benefit Resource Center, as well as insurance carriers.

Check Out the App
Download the mobile app to your smartphone. Scroll through the intro pages and, when prompted, enter the code Q84759 (UHC medical plans) or E34170 (Kaiser medical plan) to see your plan information.



Who to Contact

CARRIER/BENEFIT	WEBSITE	PHONE NUMBER
Cigna		
Medical and Prescription	www.cigna.com	866-494-2111
Sun Life		
Dental	www.sunlife.com	800-247-6875
Vision	www.sunlife.com www.vsp.com	800-247-6875
Life and AD&D Insurance	www.sunlife.com	800-247-6875
Short-Term Disability Long-Term Disability	www.sunlife.com	800-247-6875
Work Life Service - ComPsych		
Employee Assistance Program (EAP)	www.compsych.com	877-595-5281
Fidelity Investments		
401(k) Retirement Plan	www.401k.com	800-835-5097
Health Savings Account (HSA)	www.fidelity.com	800-544-3716
Norton Lifelock		
Identity Theft	www.gendigital.com	800-607-9174

FOR FURTHER ASSISTANCE, CONTACT:

Cindy Greenbaum, SPHR, SHRM-SCP Director of Human Resources	cgreenbaum@meridianwaste.com	770-691-6370

Required Notifications

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

NEWBORNS ACT DISCLOSURE - FEDERAL

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Cynthia (Cindy) Greenbaum
5925 Carnegie Blvd, Suite 370
Charlotte, NC 28209
770-691-6370
cgreenbaum@meridianwaste.com

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

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html**.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases we never share your information unless you give us written permission:

  Marketing purposes

  Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice
- Effective Date of this Notice: January 1, 2025
- Privacy Official: Cynthia (Cindy) Greenbaum, 770-691-6370, cgreenbaum@meridianwaste.com

Important Notice from Meridian Waste Acquisitions 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 Meridian Waste Acquisitions 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.**

1. **Meridian Waste Acquisitions has determined that the prescription drug coverage offered by the Meridian Waste Acquisitions Plan 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 Meridian Waste Acquisitions coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Meridian Waste Acquisitions coverage, be aware that you and your dependents will be able to get this coverage back.

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 Meridian Waste Acquisitions 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 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

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).

Date: January 1, 2025
Name of Entity/Sender: Meridian Waste
Contact--Position/Office: Cynthia (Cindy) Greenbaum
Address: 5925 Carnegie Blvd, Suite 370, Charlotte, NC 28209
Phone Number: 770-691-6370

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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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+)	**FLORIDA – Medicaid**
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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – 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	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)	**KANSAS – Medicaid**
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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	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	**MASSACHUSETTS – Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – 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	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	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	**NEW YORK – Medicaid**
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	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	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	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 2024, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

Plan Year -2025