WASTE MANAGEMENT

Health & Welfare Benefits

Summary Plan Description



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An Introduction to Your Health and Welfare Plan

The Waste Management Health and Welfare Benefits Plan allows you to choose among different levels and types of coverage. You may want or need some of these coverages but not others, or you may want a higher level of a specific coverage but not another. In addition, your personal situation may change from year to year.

The program's approach allows you to:

- ➤ Put together a mix of benefits that meets your needs
- ➤ Change your benefits every year during the annual enrollment period or if you experience a change in status. Each fall, you re-enroll for coverage for the following calendar year
- ➤ Receive significant tax advantages by paying for benefits on a pre-tax basis (when permissible)

The Components of Your Benefits Program

The chart below shows the different coverages available. It also shows which coverages Waste Management (WM) pays for, which coverages you pay for on your own, which coverages you and WM pay for together, and how you pay your share of the cost (pre- or after-tax).

Coverage	WM Pays	You Pay	You & WM Pay	You Pay Pre- or After-Tax
Medical (includes prescription drugs and behavioral health)			X	Pre-Tax**
Dental			X	Pre-Tax**
Vision		X		Pre-Tax**
Employee and Family Assistance Program	X			N/A
Flexible Spending Accounts		X		Pre-Tax**
Employee Life and AD&D*				
• Employer Paid	X			N/A
• Optional		X		After-Tax
Dependent Life and AD&D				
• Employer Paid	X			N/A
• Optional		X		After-Tax
Disability (STD/LTD)	X			N/A
Legal Services		X		After-Tax
Adoption Assistance	X			N/A
Business Travel Accident	X			N/A

*If your employer paid life insurance coverage exceeds $50,000, you are taxed on the value of the coverage over that amount. This is added to your W-2 for tax purposes.
** Due to federal law, there are special tax consequences if you elect to cover an eligible domestic partner and any domestic partner children.

You may decline any or all of the coverages except for your WM-paid benefits: employee and family assistance program (EFAP), basic employee life and AD&D insurance, STD and LTD coverages, adoption assistance, and business travel accident insurance. If you decline coverage, you do not have coverage through WM nor will you be eligible for COBRA benefits. In addition, you may not elect coverage until the next annual enrollment period (unless you experience a qualified change in status or you qualify for an additional enrollment opportunity during the year). See page 11 for details on the few events that allow you to change your coverage mid-year.

If You Have Questions

If you have questions about your benefits, please contact the appropriate insurance carrier or third-party administrator. If you are unsuccessful, please contact the Benefits Center at 800-964-3373.

Pre-Tax vs. After-Tax

You pay for certain coverages with pre-tax dollars deducted from your paycheck each pay period. Using pre-tax dollars reduces your taxable income for federal, Social Security, and (in most cases) state income tax purposes and your income is not affected when determining your benefit levels for other coverages under the Waste Management Health and Welfare Benefits Plan. This means that you pay for the coverages without a tax cost. For many, this tax advantage may be significant.

Due to federal law, however, you are taxed on the value of the coverage (i.e., amount of the company subsidy and your contributions) for any eligible dependent who is not your dependent for federal income tax purposes; this includes your domestic partner and/or your domestic partner's children, however, it does **not** include your same-gender spouse, assuming that your marriage was valid in the jurisdiction in which it was performed, or your adult children up to age 26 for whom you purchase medical coverage. This taxation is referred to as imputed income. If you believe that your domestic partner and/or your domestic partner's children qualify as dependents for federal income tax purposes, contact the Benefits Center. Remember, your domestic partner and/or your domestic partner's children only qualify as "eligible dependents" under the plan if you certify online or through the Benefits Center that they qualify as a domestic partner or the children of a domestic partner.

Please note: Using pre-tax dollars can affect any Social Security benefits you may eventually receive. This is because you do not pay Social Security (FICA) taxes on pre-tax dollars. The reduction is typically more than offset by the tax savings you experience over the course of your career. If you have any concerns, or if you need additional information, contact your local Social Security Administration office.

You pay for other coverages on an after-tax basis. This means that you pay for the coverages with your already-taxed dollars (your take-home pay). Your after-tax contributions are also deducted from your paycheck each pay period. IRS rules determine how each benefit you receive is taxed.

Self Insured and Fully Insured

The following chart shows which benefits are self insured by WM and which are fully insured.

	Self Insured	Fully Insured
Benefits	Build Your Own and EPO medical plans (includes prescription drugs and behavioral health) High Deductible Health Plan Dental STD EFAP Flexible Spending Accounts Adoption Assistance	Medical HMOs (generally) Vision Life and AD&D LTD Legal Services Business Travel Accident
Definition	As claims are made, covered benefits are paid from WM's general assets. In addition, WM has administrative services contracts with third-party administrators to decide on and process claims.	An insurance carrier provides administrative services and makes decisions regarding benefits. The insurance carrier insures coverages and makes benefit payments. WM pays premiums to the insurance carrier for coverages from its own funds as well as employee payroll deductions.

Overview

This handbook, which serves as the Summary Plan Description (SPD) required by the Employee Retirement Income Security Act of 1974 (ERISA), summarizes the major features of the benefits program for U.S. salaried and hourly employees of WM as of January 1, 2014. The formal name of the plan is the Waste Management Health and Welfare Benefits Plan.

This handbook applies to all U.S. full-time, eligible employees of WM on their 91st day of employment. "Full-time" refers to employees who are regularly scheduled to work at least 30 hours per week. This handbook does not apply to employees if health and welfare benefits are subject to collective bargaining and the applicable collective bargaining agreement does not specifically provide for coverage under the plan or provides for different coverage.

This handbook is based on the official insurance contracts and legal plan documents in effect. Every effort has been made to give you correct and complete information about your benefits program. However, if this handbook inadvertently says anything that disagrees with the official insurance contracts in effect or the official plan documents, the official insurance contracts and documents govern. You may obtain a copy of the official insurance contracts and plan documents from the Plan Administrator. See page 166 in the ***Administrative Information*** section for the full name and address of the Plan Administrator.

WM intends to continue the benefits program as described in this handbook indefinitely but reserves the right to change or even terminate all or any part of the coverages at any time and in any manner to the extent permitted by law. As a result, this handbook is not a contract, nor is it a guarantee of your benefits.

The Plan Administrator has determined that the plan is not a "grandfathered health plan" under the federal health care reform law, officially known as the Patient Protection and Affordable Care Act. As such, the plan has been updated to comply with applicable health care reform provisions and the Plan Administrator intends to administer the plan in accordance with those provisions.

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Who is Eligible

You

You are eligible to participate in the benefits program if you are a regular, non-union (union if provided for by a collective bargaining agreement), full-time, U.S. employee. If you are employed in Massachusetts and are a part-time employee, you are eligible for the medical and prescription drug programs but you must pay 100 percent of the cost of coverage for those programs.

You are a regular full-time employee if you are regularly scheduled to work at least 30 hours a week. For example, if you are regularly scheduled to work 20 hours a week, you are not a full-time employee. On the other hand, if you are regularly scheduled to work 30 hours a week but you do not work 30 hours in a week due to vacation, you are still a full-time employee. If you are usually scheduled to work 30 hours a week but you do not work 30 hours a week due to a lockout or strike, you are not a full-time employee. If you are a seasonal employee, you are not a full-time employee.

For most of the coverages, you must be employed 90 days before you become eligible and your eligibility begins on your 91st day of employment. However, you become eligible for business travel accident coverage on the first day of your employment.

Employees subject to a collective bargaining agreement may be eligible to participate if the agreement provides for participation in the benefit program.

Your Eligible Dependents

Certain coverages also are available to your eligible dependents. Generally, your eligible dependents (proof of dependent status may be required) include your spouse and children. **There are different eligibility rules for your children for the different plan coverages**.

Please Note

If you reside in Texas, the maximum age for dependent children who are not full-time students is 24 for purposes of the vision coverage.

- **Spouse.** For all coverages, “spouse” means the individual to whom you are legally married through a governmental or religious ceremony, a common law marriage or civil union unless you are legally separated. It includes your same-gender spouse, who has met all the requirements of a valid marriage contract in a jurisdiction which recognizes the marriage and who meets the requirements of a spouse under federal tax law. It can also mean your domestic partner. Your domestic partner and you must meet the following criteria:
  - Are the same gender
  - Are at least age 18
  - Are not legally married to another person or part of another domestic partner relationship
  - Reside together in the same principal residence
  - Share joint responsibilities for your common welfare and financial obligations
  - Refer to each other as “spouse”
  - Have not had a different domestic partner within the past six month period
  - Certify online or through the Benefits Center that your dependent qualifies as a domestic partner.
  - If you meet the criteria outlined above, your domestic partner and your domestic partner’s children are considered eligible dependents. You must certify that your dependent qualifies as a domestic partner for coverage to be effective.

- **Children**. *For medical, prescription drug coverage, the health care flexible spending account, and the employee and family assistance program,* children until they reach age 26, regardless of marital or student status, including your:
  - Natural children
  - Stepchildren living in your home
  - Domestic partner's dependent children
  - Legally adopted children
  - Foster children
  - Children placed with you for adoption
  - Grandchildren born to your eligible dependent child provided both live in your home
  - Children for whom you are legal guardian
  - Children (as described previously) over age 26 who are wholly dependent on you because of a mental or physical disability. Proof of a mental or physical disability is required and must be submitted and approved. (Your child's coverages continue as long as your own coverages continue.)
- **Children**. *For dental and vision coverage*, unmarried dependent children until they reach age 19 (or age 26 if a full-time student at an accredited school), including your:
  - Natural children
  - Stepchildren living in your home
  - Domestic partner's dependent children
  - Legally adopted children
  - Foster children
  - Children placed with you for adoption
  - Grandchildren born to your eligible dependent child provided both live in your home
  - Children for whom you are legal guardian
  - Children (as described above), over age 19 (or age 26) who remain wholly dependent on you because of a mental or physical disability. Proof of a mental or physical disability is required and must be submitted to and approved. (Your child's coverages continue as long as your own coverages continue.)
- **Children.** *For dependent life insurance (basic and optional) and accidental death and dismemberment insurance (basic and optional)* include:
  - Your eligible dependent children who are unmarried and supported by you until they reach age 19 (or age 26 if a full-time student at an accredited school), including your:
    - Natural children
    - Stepchildren living in your home
    - Domestic partner's dependent children
    - Legally adopted children
    - Children placed with you for adoption
  - Children (as described above) who remain wholly dependent on you because of a mental or physical disability. Proof of a mental or physical disability is required and must be submitted and approved. (Your child's coverages continue as long as your own coverages continue.)
  - For purposes of the dependent life insurance benefit, your "child" only includes your legal child(ren) from birth (live birth). It does not include an unborn child or a stillborn child.

Please note: If you reside in Louisiana, your dependent children may only be covered through age 17 (coverage ends at age 18) for both basic and optional dependent life insurance and AD&D coverage.

WM reserves the right to verify your dependent's eligibility at any time through a dependent audit. If requested, you must provide proof of your dependent's eligibility. If you fail to provide satisfactory proof of eligibility to either WM or an independent eligibility verification firm designated by WM, your dependent will be deemed ineligible and his or her coverage will terminate immediately.

Qualified Medical Child Support Order (QMCSO)

The plan also provides coverage for your child pursuant to the terms of a Qualified Medical Child Support Order (QMCSO), even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment season restrictions which might otherwise exist for dependent coverage. A QMCSO can require the plan to provide medical, dental, vision, and/or employee and family assistance coverage to a child. If the plan receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the affected child.

A QMCSO is either a National Medical Child Support Notice issued by a state child support agency or an order or a judgment from a state court or administrative body directing WM to cover a child as your dependent under the plan. Federal law provides that a QMCSO must meet certain form and content requirements in order to be valid. If you have any questions or if you would like to receive a copy of the written procedure for determining whether a QMCSO is valid, please contact the Waste Management Service Center (WMSC) at 800-964-3373 or your local Human Resources representative.

You must report a QMCSO to the WMSC within 30 days of receipt for coverage to be effective back to the date the order was issued. If you contact the WMSC after 30 days, coverage will be effective as of the date you call.

Dual Coverage

If WM employs both you and your spouse, only one of you may cover your children as dependents under any one coverage. If you have coverage as an employee, you may not also be covered as a dependent under the WM plan. Additionally, if your child works for WM and is under age 26, he or she can only be covered as an employee or a dependent under the WM medical plan.

The dependent life insurance options do not cover dependents who are also regular, full-time employees of WM. In that situation, each person is covered as an employee.

How to Enroll

New-Hire Enrollment

After you have been employed at WM for 30 days, an enrollment package with instructions on how to enroll will be mailed to you. The enrollment period is 90 days from date of hire for newly hired employees. **This means you must enroll within 90 days of your hire date.**

If you are rehired within 365 days of a separation from WM, you were previously covered by the plan, and you return to work in a different plan year, you have 30 days to re-enroll. In this case, if you do not re-enroll within 30 days, you will be defaulted into the benefit options you had when you most recently discontinued employment at WM (to the extent these options are available), except for Flexible Spending Accounts. If you wish to enroll in Flexible Spending Accounts, you must re-enroll within 30 days of your rehire. If an option you were enrolled in is no longer available, you will be defaulted into an alternate option, if one exists. If you were rehired within the same plan year, you will be defaulted into the coverages and coverage levels you had when you separated from WM. If you experienced a change in status during your separation period from WM, you must report the event within 30 days of your rehire to be eligible to change your coverage.

Your enrollment information is designed to help you make your coverage selections using the WM benefits enrollment system, either online or by telephone if you do not have a WM email account or online access. Be sure to enroll within the time period printed on your worksheet. If you do not enroll, you **will not have** the following coverages: medical (including, behavioral health and prescription drug), dental, vision, basic spouse or dependent life insurance, optional employee and dependent life and AD&D, flexible spending accounts, and legal services. As a result, you must wait until the next annual enrollment period to elect one or more of these coverages.

If you enroll online, you can print a copy of your confirmation statement or call and request a paper copy be mailed to you. If you enroll over the phone, a confirmation statement will be mailed to you. If there is a discrepancy, you must contact the Benefits Center immediately. The coverage options you select remain in effect until the end of the plan year (December 31), unless you have a qualified change in status. See page 11 for details on change-in-status enrollment.

Please note: During your initial enrollment, you may choose any coverage option available (subject to plan limitations). If you want to change coverage at a later annual enrollment, restrictions may apply. See the following ***Annual Enrollment*** section for details.

Annual Enrollment

Each fall, you may elect coverage for the following plan year (January 1 - December 31). The elections you make during annual enrollment generally take effect on the following January 1, the start of the new plan year.

Before enrolling, you will receive information that is designed to help you make your annual enrollment elections. The information describes the enrollment procedures, the coverage options available for the upcoming plan year, and any changes to the available coverages since the last enrollment. Your enrollment materials contain important tips on how to enroll. Be sure to read the information carefully.

If you want to increase certain coverages for you or your dependents during annual enrollment, certain restrictions may apply. For example, you may have to provide evidence of insurability by completing a statement of health with MetLife if you or your dependents want to increase the level of optional employee or dependent life insurance coverage.

If you do not enroll during the annual enrollment period but you were enrolled during the prior plan year, most of your coverages remain in effect for the following plan year unless otherwise stated in the enrollment materials. The only exception is the Flexible Spending Account. If you want to participate in a Flexible Spending Account, you must re-enroll during each annual enrollment period. Generally, if you do not enroll during annual enrollment and your current option is no longer available, you will default into an alternative option.

Enrollment Pursuant to a QMCSO

You, a custodial parent or a state agency may enroll your dependent child in medical (including behavioral health and prescription drugs), dental, vision, and/or employee and family assistance coverage pursuant to the terms of a valid QMCSO (qualified medical child support order). A child who is eligible for coverage pursuant to a QMCSO may not enroll dependents for coverage.

A dependent can be enrolled for medical, dental and/or vision coverage pursuant to a valid QMCSO only if any required contributions are made. This means that any required contribution for your dependent child’s coverage will be withheld from your paycheck unless a state agency pays the required contribution.

ID Cards

Within a few weeks of your enrollment, you will receive identification cards for the coverages you enroll in at your home address. One card applies to medical and behavioral health. A second card applies to prescription drug coverage. A third card applies to dental coverage. Vision coverage does not require an ID card; simply identify yourself as a VSP plan participant.

When Coverages Begin

If you complete the enrollment process in a timely manner, you start participating in your health and welfare benefit coverages on your 91st day of employment (except for business travel accident which begins on your first day of active employment). For example, if you are hired on March 16 and you enroll on or before June 12 (your 90th day of employment), your coverages begin on June 13 (your 91st day of employment). Your dependents' coverages begin on the same day that your coverages begin, or the day they first become eligible (whichever is later). See ***Changing Your Coverages*** for details on adding a dependent to coverage because of a change in status or special enrollment right. For purposes of life and AD&D and disability coverages, you must be "actively at work" on your 91st day of employment for coverage to become effective. Actively at work means you are performing all of the material duties of your job with WM where these duties are normally performed. You are actively at work on a day that is not one of your scheduled workdays if you were at work on the preceding scheduled day.

If you are not actively at work on your 91st day of employment, your life, AD&D and disability coverages become effective on your first full day at work (after your 91st day).

Also, if you do not enroll on time, you will only be provided the following Company-paid benefits: basic employee life and AD&D, disability, EFAP, adoption assistance, and business travel accident.

Cost

You pay the entire cost of:

- Vision
- Employee optional life and AD&D insurance
- Dependent optional life and AD&D insurance
- Legal services

If you elect to, you can also contribute to an HSA and/or flexible spending accounts.

For all other coverages, WM pays either a major portion or all of the cost. The amounts you are required to pay are made with either pre-or after-tax dollars deducted from your pay. See pages 1-2 for details. Your coverage cost may change each plan year. The most up-to-date cost of each coverage can be found online at mywmtotalrewards.com or by calling the Benefits Center. Coverage under the plan is subject to payment of any required contribution unless, in the case of a child who is eligible for coverage pursuant to a QMCSO, payment of the required contribution is made by a state agency.

Changing Your Coverages

Because of the tax advantages that apply to the Waste Management Health and Welfare Benefits Plan, federal rules and regulations restrict your ability to change your benefits and change your covered dependents after initial enrollment. These rules and regulations govern the types of changes that you may make during the calendar year. In general, once you enroll for (or decline) coverage, your benefit elections and covered dependents stay in effect for that calendar year. However, under certain circumstances, you may enroll in certain coverages, add or subtract covered dependents or change certain coverages during the year. For example, you may change your coverage if you experience one of the following events and notify the Benefits Center within 30 calendar days:

- You experience a "change in status" – as described in this section – that affects your, your spouse's or your dependents' eligibility for plan benefits
- You qualify for a special enrollment during the year under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as described on page 12
- The Plan Administrator receives a QMCSO or other court order, judgment or decree requiring you to enroll a dependent child in the plan
- You, your spouse or your dependent qualifies for or loses Medicare or Medicaid coverage
- You take a leave of absence under the Family and Medical Leave Act (FMLA) or an unpaid military leave (you may switch coverage only when you begin, or return from, the leave of absence)
- A new collective bargaining agreement covering you is ratified that provides for different benefits under the Plan

Changes in Status

You may change certain benefit elections during the plan year if you experience a change in status. Depending on the event that you experience, you may change your medical, dental, vision, life and AD&D (may require evidence of insurability) coverages. You also may be able to change the amounts you contribute to your flexible spending accounts depending on the change in status, and you may be able to add or remove dependents from coverage. A change in status is any of the following:

- You get married, divorced, legally separated or you have your marriage annulled
- Your spouse or dependent dies
- Your dependent becomes eligible for coverage or ineligible for coverage (e.g., reaches the eligibility age limit, becomes or ceases to be a student, or gets married)
- You or your spouse has a baby, you adopt or you have a child placed with you for adoption
- You, your spouse or your dependents experience a change in employment status (e.g., start or end employment, strike or lockout, begin or return from an unpaid leave of absence, change work sites, change from part-time to full-time or vice versa), or experience a change in employment that leads to a loss of or gain in eligibility for coverage
- Your home residence changes and your previous coverage is no longer available (for example, you move outside your HMO's service area) or new coverage options become available
- You, your spouse or your dependent experiences a significant, unexpected and unforeseen increase (or decrease) in the cost of coverage (this does not apply to your Health Care Flexible Spending Account)

Regardless of what type of change in status you have, any election change you make under the Waste Management Health and Welfare Benefits Plan must be because of and consistent with the change in status.

If you experience a change in status, you must call the Benefits Center (or for a marriage, birth, adoption or divorce, log on to mywmtotalrewards.com) within 30 days after the event to change your coverage. You may be required to provide proof of the change. If you do not report the change within 30 days after the event, you cannot change your coverage until the next annual enrollment, unless you once again meet one of the conditions for a mid-year change. Further, if the Plan determines that you fraudulently or

intentionally misrepresented your dependent's eligibility, you can face even greater consequences, including retroactive termination of coverage and the requirement to repay all medical expenses incurred under the Plan by you or your dependent.

A Note About Life Insurance Election Changes

The following special rules apply to optional life insurance election changes (for you, your spouse or your dependents):

- In the case of birth, adoption or placement for adoption, you may increase or decrease coverage (subject to the evidence of insurability requirements)
- In the case of your spouse or dependent's death, you may increase or decrease coverage (subject to the evidence of insurability requirements)

Special Enrollments During the Year

If the medical plan coverage for yourself and/or your dependents (including your spouse) is "Opt Out or Waive" – and you certified that you have other coverage – the Health Insurance Portability and Accountability Act (HIPAA) allows you to enroll mid-year if that other health coverage ends. To enroll, you must call the Benefits Center within 30 days after your other coverage ends. As long as you call within the 30-day period, coverage takes effect on the date of your special enrollment right. If you do not call the Benefits Center within 30 days, you must wait until the next annual enrollment to elect coverage.
In addition, if you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you can enroll yourself and your dependents (including your spouse). However, you must call the Benefits Center or log on to mywmtotalrewards.com within 30 days after the marriage, birth, adoption or placement for adoption. As long as you call within the 30-day period, coverage takes effect on the date of your special enrollment right (the marriage or your child's date of birth, for example). If you do not call the Benefits Center within 30 days, you must wait until the next annual enrollment to elect coverage.

You may be eligible to enroll in medical coverage mid-year if you or your dependent child:

- Lose coverage under a Medicaid Plan under Title XIX of the Social Security Act
- Lose coverage under CHIP under Title XXI of the Social Security Act
- Become eligible for group health plan premium assistance under Medicaid or CHIP

To enroll in medical coverage, you must call the Benefits Center at 1-800-964-3373 and elect to enroll within 60 days after you lose coverage, or become eligible for premium assistance.

Coverage During Family Medical Leave

In the event you qualify for unpaid leave of absence under the FMLA, you may (i) continue to participate in the plan, (ii) change certain benefit elections or (iii) terminate participation in the plan. Any changes to your benefit elections can be made for yourself or your dependents.

Changing Coverages

Upon commencement of or return from a leave of absence under the FMLA, you may continue to participate in the plan without making any changes to your existing coverages. If you elect this option, your benefit elections in effect on your first day of such leave will remain in effect, provided you do not experience a change in status. A second option allows you to continue participating in the plan and also change certain benefit elections. Finally, you may terminate participation in the plan altogether upon commencement of or return from a leave of absence under the FMLA. If you elect to either change certain benefit elections or terminate participation in the plan, you must notify the Benefits Center within 30 days of the commencement of or return from your approved leave of absence. Otherwise, you cannot

change your benefit elections until the next annual enrollment period unless you experience a change-in-status event.

Coverage During Other Unpaid Leaves

In the event you qualify for an approved unpaid leave of absence (other than a FMLA leave), you may continue to participate in the plan based on your existing elections, discontinue participating or change certain benefits.

Cost Of Coverages During A Leave

If you continue to participate in the plan during your unpaid FMLA leave or during an unpaid leave of absence, you must still make your required contributions for certain coverages. You will receive a monthly bill to pay for your coverages. If you fail to pay your bill within 30 days of the due date, you may lose coverage under the plan.

You have the option of paying for coverage through direct debit of your bank account. You can sign up for direct debit on mywmtotalrewards.com or by calling the Benefits Center if you do not have online access.

Coordination of Benefits

Your medical and dental coverages coordinate benefits with other group plans that may cover you and/or your dependents. This feature helps prevent duplication of benefit payments for the same services. It is your responsibility to notify the applicable carrier if you are covered by other plans.

Coordinating Plans

The following types of plans normally coordinate benefits:

- Plans provided by an employer, union, trust or similar sponsor
- Other group health care plans that cover you or your dependents, including student coverage provided through a school above the high school level
- Government benefit programs provided or required by law, including Medicare and Medicaid
- Automobile insurance plans

Your medical and dental coverages will consider any benefits to which you may be entitled from other group plans (even if you do not request payment from them) when determining the benefit payments made under the WM plan.

How Coordination with Other Coverages Works

If you are covered by more than one group plan and/or other coverages (e.g., “no-fault” coverage), one is primary. The primary plan or coverage pays benefits first without considering the other plans or coverages. Then, the other plans or coverages pay benefits.

If your WM medical or dental coverage is primary, the plan pays benefits up to the limits described in this handbook. When the WM coverage is the secondary, it figures its regular benefit as if it were primary, subtracts from that amount the primary coverage’s benefits and then pays the difference.

Determining the Order of Payment

When benefits coordinate, the plans and/or coverages determine which one pays benefits first, second, etc. Here are guidelines for determining which plan or coverage is primary:

- Medical and/or dental benefits under automobile “no-fault” and traditional “fault” insurance or other coverage, or long-term care coverage, or personal injury coverage automatically are primary
- If one plan has no coordination-of-benefits provision, it automatically is primary
- The plan covering the person as an employee rather than as a dependent is primary
- When both married parents’ plans cover a dependent, the plans use the birthday rule to determine which parent’s plan pays first. The plan of the parent whose birthday comes earlier in the calendar year is the primary plan, and the other parent’s plan is secondary. If both parents have the same birthday, the primary plan is the one that covered the parent longer
- In the case of a divorce or separation, the plan of the parent who has custody of the dependent child pays benefits first. If the parent with custody remarries, the stepparent’s plan pays second, and the plan of the parent without custody pays third. However, if there is a court order requiring a parent to take financial responsibility for the child, that parent’s plan always is primary
- If these rules do not determine the order of payment, the plan that has covered the person the longest is the primary plan

How Coordination with Medicare Works

Your medical benefits may coordinate with Medicare. How the WM plan coordinates with Medicare depends on your age and whether you are an active or inactive employee. If you are an active employee and you are Medicare-eligible, WM's medical plan is primary and pays benefits as described in this handbook. If you are an inactive employee and Medicare eligible, WM's medical plan is secondary.

If the plan is secondary to Medicare, the plan pays the difference between what Medicare would pay and the benefits available under the plan. If under the plan's rules it is secondary to Medicare, the plan will pay benefits assuming that you are covered under all applicable parts of Medicare. If you do not enroll in Medicare, the plan will still pay reduced benefits as if you were covered under Medicare. If the plan is secondary to Medicare and you have enrolled in Medicare, be sure to submit the explanation of benefits (EOB) you receive from Medicare when you file a medical claim under the plan. The combination of what Medicare pays and what the plan pays may not exceed what the plan alone would have paid.

Under current law, you and your dependents become eligible for Medicare at age 65. If you become disabled, you may become eligible for Medicare before age 65. Please notify the claim administrator/insurance company once you start Medicare benefits.

If You are an Active Employee

If you are an active employee and you or your spouse reaches age 65, you or your spouse has coverage either:

- Under both the WM medical plan and Medicare (the medical plan is primary and Medicare is secondary)
- Under Medicare only because you were not already covered under WM's plan.

Your spouse, if age 65 or older, may make a Medicare election separate from yours. He or she, however, may not elect coverage under WM's plan if you do not elect coverage.

Please note: If you or your covered dependent has end-stage renal disease, the WM plan's primary status applies during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, Medicare becomes primary. If you or your covered dependent has end-stage renal disease and Medicare becomes primary, you need to enroll in all applicable parts of Medicare because the WM medical coverage will only pay as secondary. When the WM medical coverage pays secondary, it reduces the benefits provided under the plan by the amount all applicable parts of Medicare would pay-even if you are not enrolled in all applicable parts of Medicare. Contact your local Social Security Administration office to get more information about enrolling in Medicare.

If You are an Inactive Employee

If you are an inactive employee (e.g., you are on a disability leave or you terminated employment and elected continuation benefits (COBRA)) and you or your spouse is Medicare-eligible, Medicare is primary regardless of your or your covered spouse's age. In that case, you need to enroll in all applicable parts of Medicare because the WM medical coverage will only pay as secondary. When WM medical coverage pays secondary, it reduces the benefits provided under the plan by the amount Medicare would pay under all applicable parts-even if you are not enrolled in all applicable parts of Medicare. You are responsible for notifying WM if you or your spouse becomes Medicare-eligible.

Subrogation and Reimbursement

The Health and Welfare Benefits Plan does not cover expenses for services and supplies relating to an illness, injury, disability or death as a result of the actions of a third party that may be liable for such expenses or relating to a condition that occurs pursuant to an agreement with a third party. This exclusion from coverage also applies to expenses for which payment may be made under any automobile policy, homeowner's policy, workers' compensation, or similar insurance coverage, or under a surrogacy agreement. However, in certain cases the plan may advance you payment of the expense as a benefit in exchange for you and/or your dependents granting the plan the right of subrogation, reimbursement and recovery. The following rules apply to all persons covered under the plan:

- **Reimbursement agreement** – If you have expenses that are excluded because they are or may be the responsibility of a third party, in order to receive plan benefits you must sign the plan's reimbursement agreement. The agreement acknowledges your obligation to reimburse the plan from the first dollars recovered from any source. If the expenses are incurred by a minor dependent, the Plan Administrator may require that the minor's parent or legal guardian execute the reimbursement agreement and agree to be bound by it. The Plan Administrator may, in its discretion, withhold benefit payments that might otherwise be advanced, and/or prosecute an action at law or in equity in its own name or in your name, in order to enforce, secure, or protect the plan's rights. If you do not execute the agreement, the plan is not obligated to provide any benefit payments.
- **Right of reimbursement** – Whether or not you execute a reimbursement agreement, in the event that the plan provides benefits and you, your dependent or your representative recovers a payment, either by settlement, judgment, surrogacy agreement, plasma donation arrangement, no-fault automobile insurance statute, or otherwise, from any third party, then you, your dependent, or your representative must immediately reimburse the plan for the full amount of any and all benefits paid in connection with the injury, illness, disability or death, up to the amount of recovery. This right of reimbursement applies to the full amount of the recovery regardless of the label assigned and any purported allocation or itemization of such recovery to specific types of injuries. If the recovery is for damages other than for medical or dental care expenses, such as pain and suffering, you will still be required to reimburse the plan first. The plan has a lien on any such recovery in the amount of benefits paid by the plan. The plan's right of reimbursement shall apply to the first dollar of any recovery from the third party, even if the recovery is less than the amount needed to make you whole.
- **Right of subrogation** – Whether or not you execute a reimbursement agreement, you, your dependent or your representative agrees that as a condition of receiving benefits under the plan, the plan shall have the right of subrogation with respect to the full amount of benefits paid to or on your behalf as the result of an injury, illness, disability or death that is or may be the responsibility of any third party, or as a result of a condition pursuant to a surrogacy agreement. The plan shall also have a lien on any recovery from such third party to the full amount of benefits paid and may, at its option, file suit or intervene in any pending lawsuit to secure and protect its rights. The plan's right of subrogation shall apply to the first dollar of any recovery obtained from the third party, even if the recovery obtained is less than the amount needed to make you whole.
- **Duty to cooperate** – You, your dependents and your representatives are required to cooperate fully with the plan in connection with the exercise of its rights, to provide such information, assistance and documents as the plan may require to help enforce its rights, and to not do anything to hurt such rights. You, your dependent or your representative must notify the plan before filing any suit relating to an illness, injury, disability or death as the result of action of a third party, and may not settle any such claim against a third party without giving notice to and obtaining the consent of the Plan Administrator.
- **Attorney Fees** – The plan is not responsible for attorney fees, expenses, or costs, incurred by you, your dependents or representatives. If you do not timely notify the plan of suit or settlement, do not cooperate with the plan, or oppose the plan in enforcing the plan's subrogation or reimbursement rights, you must pay the plan's attorneys' fees and costs incurred as a result of your actions or failure to act, in addition to any other rights or remedies that the plan may have.

- **Right of recovery or offset** – The plan has the right to withhold the payment of benefits under this plan if you, your dependents, or your representatives do not comply with these requirements, and has the right to recover any benefits paid to you or your health care provider in error. The plan may stop paying benefits under the plan if the Plan Administrator determines that you, your dependents, or your representatives have failed or are failing to fulfill the duty to cooperate, and/or that you, your dependents, or your representatives received a payment from a third party and did not repay the plan. These rights are in additional to any other rights and remedies that the plan may have.

How Long Coverages Continue

Generally, your coverages continue while you are still employed by WM and contributing your appropriate share of the cost.

When Coverages End

In general, your coverages end on the day that:

- Your employment with WM ends (e.g., you retire, quit or otherwise terminate, including a layoff)
- You are no longer eligible to participate
- You stop making required contributions for plan coverage
- You elect to terminate coverage
- You go out on strike or you are locked-out

Your long-term disability coverage ends on the date you cease to be an active full-time employee, except for regularly scheduled absences (like vacation or sick days), FMLA leave or military leave.

Your dependents' coverages end on the day yours end, or on the day which your dependent no longer meets the eligibility requirements (whichever occurs first).

When any of the following happen, you will receive written notice that your coverage (and coverage for your dependents) will end on the prospective date identified in the notice:

- Fraud or misrepresentation, or because you (or one of your dependents) knowingly gave the Plan Administrator, an Insurer or Claim administrator, false, material information. Examples include false information relating to a person's eligibility or status as a dependent
- You (or one of your dependents) permitted an unauthorized person to use one of your ID cards, or you (or one of your dependents) improperly use another person's card
- You (or one of your dependents) commit acts of physical or verbal abuse that pose a threat to the staff of the Plan Administrator, an Insurer or Claim administrator
- You (or one of your dependents) in any other way materially violates the terms of the Plan

In the event of fraud or intentional misrepresentation of material fact, your medical coverage may be rescinded retroactively. You will receive a notice at least 30 days before such a rescission becomes effective. Examples of fraud or intentional misrepresentation of material fact include false information relating to a person's eligibility or status as a dependent; filing a false or fraudulent claim; filling forged prescriptions; you (or your dependents) knowingly permitting an unauthorized person to use one of your ID cards, or you improperly use another person's card (or one of your dependents improperly uses another person's card and you know about it).

If you intend to leave WM, be sure to check with the Benefits Center or your local Human Resources representative about your benefit status as soon as possible. You may use the existing balance in a flexible spending account for any claims you incur before your termination date. In addition, you may be able to elect COBRA coverage or convert certain coverages to individual policies if you no longer qualify for group coverage through WM.

Conversion Rights

When certain group coverages end, you or your covered dependents may obtain individual insurance coverage with the same insurance company without undergoing a medical examination. This is called a "conversion right," and applies to the following plans:

- Employee basic and optional life insurance
- Dependent basic and optional life insurance
- Long-term disability insurance

To convert to an individual policy without a gap in coverage, you or your dependent must apply for conversion with the appropriate insurance company within 31 days after WM's coverage ends. However, if you apply to convert your LTD coverage more than 31 days after your WM coverage ends, but before 62 days, you must provide evidence of good health and you will have a gap in coverage beginning 31 days after your WM coverage ends.

If your life insurance coverage ends and you die during the 31-day conversion period, your beneficiary receives the benefit that would have been paid if you converted to the individual policy. This is true regardless of whether or not you actually applied for conversion.

For more information about your life insurance conversion rights, the amount of coverage you can convert and the costs, contact MetLife at 877-275-6387. For long-term disability insurance conversion information, contact Cigna at 800-441-1832.

Continuation of Benefits (COBRA)

If you and your dependents have health care coverage (i.e., medical, dental and/or vision coverage) through WM and that coverage ends, you may continue coverage for a specified period, depending on the reason coverage ends. An event that allows you to continue health care coverage after it would otherwise end is called a "qualifying event." In addition, you and your dependents may continue participation in the health care flexible spending account (on an after-tax basis) after a qualifying event for a specific period of time. Continuation coverage is available as required by law under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

When You and/or Your Dependents Elect COBRA

If you and/or your dependents choose continuation coverage through COBRA, you and your dependents are offered coverage on the same basis as other participants, except you or your affected dependents pay the entire cost. COBRA coverage is intended to extend prior coverage, rather than to create new classes of covered individuals. To be eligible for continuation of coverage, you or your dependents must be covered under the plan(s) on the date before the qualifying event.

COBRA coverage takes effect on the date of the qualifying event if a timely election is made. While WM will notify the COBRA administrator of your death, termination of employment, or loss of eligibility due to a reduction in hours, it is your responsibility to notify the Benefits Center of any other qualifying event (e.g., divorce, loss of student status). In addition, you may add a newborn or an adopted child during the COBRA continuation period in accordance with the "special enrollment" rules outlined earlier. Your newborn or adopted child's coverage begins immediately.

To continue coverage, you or your affected dependents are required to pay the entire cost, plus an administrative fee, as allowed by law.

Snapshot of COBRA Continuation Coverage

The chart below shows who is eligible for COBRA continuation coverage, under what circumstances, and how long COBRA continuation coverage continues for medical, dental and/or vision. Special time periods apply to Health Care Flexible Spending Account coverage.

If:	Qualifying Event	Who Is Eligible for COBRA Coverage	Duration of COBRA Coverage
You	Are laid off	You and your dependents	18 months
	Have a reduction in hours	You and your dependents	18 months
	Terminate employment (for reasons other than gross misconduct)	You and your dependents	18 months
	Do not return from an FMLA leave of absence	You and your dependents	18 months
	Become disabled within the first 60 days of COBRA continuation coverage	You and your dependents	Up to 29 months*
	Die	Your dependents	36 months
	Become divorced or legally separated	Your dependents	36 months
Your dependent	Is no longer an eligible dependent (due to age limit, divorce, or legal separation)	Your dependent	36 months
	Is no longer an eligible dependent because of your death	Your dependent	36 months
	Becomes disabled within the first 60 days of COBRA continuation coverage	You and your dependent	Up to 29 months*

*Includes months of COBRA coverage already used.

Employee Loses Coverage

If you lose coverage because of a layoff, reduction in hours (including strike or lockout), termination of employment (for reasons other than gross misconduct), or if you do not return to work after an FMLA leave of absence, COBRA continuation coverage is available to you and your dependents for up to 18 months from the date of the qualifying event. The Benefits Center notifies you and your dependents when such an event makes continuation of coverages available and sends you election information, including the cost of the coverage. You must then notify the Benefits Center (within 60 days of the date the notice is sent or coverages are lost, whichever is later) of your decision to continue coverage. If you do not elect continuation coverage during the first 60 day election period and you become eligible for trade adjustment assistance, you may elect continuation coverage during a second 60-day period that begins on the first day of the month in which you are determined to be eligible for such assistance. In this situation, your election must be made within 6 months of your first COBRA continuation coverage event.

If you or your covered dependent becomes disabled within the meaning of the Social Security Act during the first 60 days of COBRA continuation coverage, you and your covered dependents may extend the 18 month continuation period to 29 months. For the 29-month continuation coverage period to apply, you must notify the Benefits Center by calling 800-964-3373 within 60 days of the determination of your disability by the Social Security Administration and within the initial 18-month continuation coverage period.

If one of your covered dependents experiences another qualifying event (for example, your child becomes no longer covered due to age) during the COBRA continuation period, the COBRA continuation period can be extended for that dependent. You or your dependent must notify the Benefits Center (within 60 days of the second event).

Dependent Continuation Coverage

Each of your dependents may have the right to COBRA continuation coverage for up to 36 months from the date of the qualifying event if your dependent loses coverage because:

- You die
- You and your spouse get divorced or legally separated
- Your dependent is no longer eligible for coverage under the plan (e.g., due to age limit)

If your dependents lose coverage because of your death, the Benefits Center will notify them of their right to continue coverage within 44 days. They must notify the Benefits Center of their decision to continue coverage within 60 days of the later of this notification or the date benefits terminate.

In the event you become divorced or legally separated or, in the event your dependent no longer meets the eligibility requirements, it is your responsibility to timely notify the Benefits Center by calling 800-964-3373 within 30 days of the event. In order to continue coverage under COBRA, your former spouse or dependent must elect COBRA continuation coverage. There are certain steps to take to secure continued COBRA coverage, including timely election and payment of premiums (see pages 18-20). If continuation coverage under COBRA is elected and payments are not timely made, for whatever reason, that coverage will be discontinued without the option for reinstatement.

If you fail to notify the Benefits Center within 30 days of a spouse or dependent losing eligibility for coverage, health insurance could be retroactively discontinued. In that case, WM may take legal steps to recover, directly from you, the higher of any amounts paid for health expenses during that time or the value of the COBRA premiums that would have been applicable. Further, if the Plan determines that you fraudulently or intentionally misrepresented your dependent's eligibility, you can face even greater benefit or employment consequences.

Cost of Coverage

You or your affected dependents are required to pay the entire cost of COBRA continuation coverage (plus an administrative fee as allowed by law) if you elect it.

When Coverage Ends

If you elect COBRA continuation coverage, it takes effect on the date of your qualifying event and continues until the earliest of the following:

- The end of the 18-month, 29-month or 36-month continuation period (for medical and dental)
- The date WM no longer provides health care coverage to any of its employees
- When there is a significant underpayment of a premium or when premiums for continuation of group coverages are not paid within the required time
- The date you or your dependents become covered under another group health care plan other than TRICARE (provided pre-existing condition exclusions or limitations under the new group health care plan do not apply)
- The date you or your dependents become entitled to Medicare*
- With respect to the 11-month extension for disability, the date the person is no longer disabled (you must notify the Benefits Center within 30 days of a determination by the Social Security Administration that you or a covered dependent is no longer disabled)

Note:** If you or your dependent becomes eligible for Medicare while covered by COBRA continuation coverage but you (or your dependent) do not enroll in Medicare, you will still receive COBRA continuation coverage but that coverage will be secondary to Medicare. See ***How Coordination with Medicare Works for more information.

If the Benefits Center determines that your coverage is terminating before the end of the 18-month, 29-month or 36-month period (e.g., when premiums are not being paid within the required time), you will be notified that your coverage is terminating and you will be provided with the reason why and the date your coverage is terminating.

Special Rules for Health Care Flexible Spending Accounts

You or your dependents are also permitted to elect COBRA continuation coverage due to a qualifying event for your health care flexible spending account by continuing contributions on an after-tax basis. The COBRA rules described on the preceding pages are the same, except that the maximum period for which you may continue after-tax contributions to your health care spending account is the remainder of the plan year in which your qualifying event occurred.

Electing COBRA for health care flexible spending accounts gives you or your dependents the benefit of extending the time period for which claims for reimbursement may be incurred. Normally, to be eligible for reimbursement, a claim must be incurred while you are covered under and contributing to the health care flexible spending account. If you have not incurred enough expenses at the time of your qualifying event to recover your contributions to the account, then you should consider electing COBRA in order to extend the coverage period long enough to incur claims that would allow for full reimbursement, but not past the end of the year. For this reason, COBRA is only available to you or your dependents if the amount you could be reimbursed exceeds the amount you would have to pay into the account on an after-tax basis.

Continuation of Benefits (COBRA) And Federal Trade Adjustment Assistance

If your employment is adversely impacted by international trade, such as increased imports or a shift in production to another country, you may become eligible for federal trade adjustment assistance (TAA). TAA benefits include a tax credit equal to 65% of COBRA premiums you pay.

If you become eligible for TAA after a termination of employment or reduction of hours and you did not elect COBRA coverage during your initial 60-day election period, you are eligible for a second COBRA election period. This second election period begins on the first day of the month in which you are determined to be a TAA-eligible individual. You must, however, make your COBRA election within six months after the date you originally lost your medical coverage. If you elect COBRA coverage during this second election period, it is effective retroactive to the first day of the second election period, not on the date you originally lost coverage. Your maximum COBRA coverage period, however, is still measured from the date you originally lost coverage.

COBRA Administrator

The Benefits Center administers WM's COBRA coverage. If you have any questions about the law or your COBRA benefits, contact Waste Management Benefits Center, 100 Half Day Road, P.O. Box 1449 Lincolnshire, IL 60069-1449 (telephone: 800-964-3373).

If you are a COBRA participant, please notify the Benefits Center if you or your spouse changes address, or if you have a change in family status which impacts your coverage.

Deadline for Filing Claims

Generally, you must file any claim for benefits within one year after you receive the covered services or supplies, or incur a covered loss, illness, or death. For any vision claim, you must file your claim for benefits within six months after you receive the covered service or supply. Any claim filed after these deadlines is not eligible for benefits under the plan.

If Your Claim is Denied

Even though it does not happen often, occasionally disagreements about benefit eligibility or amounts arise. In most cases, they are resolved quickly. However, if you are unable to resolve the disagreement, formal appeals processes are in place to help you appeal a denied claim. In no event can you (or any other person) challenge a decision in court until the applicable claims procedures have been complied with and exhausted.

Claims Processes

This section describes only the plan's claims and appeals procedures for disputes concerning enrollment and eligibility for enrollees. The claims and appeals procedures for each different coverage are described in each of the sections of this handbook.

General Eligibility and Enrollment Claims/Appeals Process

If you have questions involving eligibility for coverage or enrollment in a specific coverage (that is, a question concerning eligibility for or enrollment in a specific coverage without making a claim for benefits), you are entitled to certain claims and appeals procedures. You should send your written claim to:

Administrative Committee of the Waste Management Employee Benefits Plan
Waste Management
1001 Fannin Street, Suite 4000
Houston, TX 77002

If the Administrative Committee denies your claim for eligibility or enrollment, you will receive a notice. This notice will include reference to the specific plan provision on which the benefit decision was based and a description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary. This notice will generally be given within 90 days unless the Administrative Committee notifies you in writing that an extension (not to exceed an additional 90 days) is needed.

If you believe that a denial is still incorrect, you may send your appeal to the Administrative Committee at the address listed above within 60 days of receiving the denial notice. In connection with your appeal, you or your representative can review relevant documents and submit issues and comments in writing. The Administrative Committee will review all disputed claims and will notify you of its finding and decision in writing within 60 days (unless special circumstances require an extension not to exceed an additional 60 days) after receiving your appeal. Your notification will include reasons for the decision and references to the plan provisions on which the decision is based.

Relevant Documents

The relevant documents that must be made available to you include documents, records and other information that:

- Were relied on in deciding your benefit claim
- Were submitted, considered or generated in the course of deciding your benefit claim
- Demonstrate that the decision complied with the plan's administrative procedures or safeguards or
- State the plan's policy or guideline regarding the benefit for your diagnosis, whether or not it was relied upon

Medicare Part D Notice

Creditable Prescription Drug Coverage Notice.....24

As you may know, prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Creditable Prescription Drug Coverage Notice

This section has information about your WM prescription drug coverage and Medicare prescription drug coverage. It also tells you where to find more information to help you make decisions about your prescription drug coverage**. This notice applies to you and/or your covered family members that are eligible for Medicare.** Medicare prescription drug coverage (known as Medicare Part D) is available to everyone with Medicare. WM has determined that the prescription drug coverage offered to active employees is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay. Read this notice carefully – it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.

Creditable Coverage

Because WM's prescription drug coverage under the medical plan is, on average, at least as good as standard Medicare prescription drug coverage, you can remain enrolled in WM's prescription drug coverage under the medical plan and not pay extra if you later decide to enroll in Medicare coverage. You will have the opportunity to enroll in a Medicare prescription drug plan between October 15th and December 7th.

Your WM Prescription Drug Coverage and Medicare's Prescription Drug Coverage

If you do decide to enroll in a Medicare prescription drug plan and continue your WM coverage, your WM coverage will coordinate with your Medicare prescription drug plan according to the rules described in the ***How Coordination with Medicare Works*** section of this handbook. Keep in mind, your coverage pays for other medical expenses in addition to prescription drugs.

When WM Prescription Drug Coverage Ends

You should also know that if you drop or lose your WM prescription drug coverage and don't enroll in Medicare prescription drug coverage immediately, you may pay more to enroll in Medicare prescription drug coverage later. If after May 15, 2006, you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your Medicare prescription drug coverage monthly premium will go up at least 1% for every month after your initial enrollment period that you did not have that coverage. For example, if you go nineteen months without coverage, your Medicare prescription drug coverage premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next October to enroll.

For More Information

If you need additional information, access mywmtotalrewards.com or call the Waste Management Benefits Center toll free at 800-964-3373. Benefits Center Representatives are available between 7 a.m. and 7 p.m., Central time, Monday through Friday. The website is available 24 hours a day, Monday through Saturday, and after 12 p.m., Central time, on Sunday. Please address written correspondence to:

Waste Management Benefits Center
100 Half Day Road
P.O. Box 1449
Lincolnshire, IL 60069-1449

Note: WM may provide you with this notice at other times in the future; such as before the next period you can enroll in Medicare prescription drug coverage, and if your Waste Management prescription drug coverage changes. You also may request a copy of this notice at any time.

For More Information about Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook from Medicare. You'll get a copy of the handbook in the mail from Medicare each October. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

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

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may need to give a copy of this notice when you join to show that you are not required to pay a higher Medicare premium amount.

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Your medical coverage is a key component of your Waste Management Health & Welfare Benefits Plan. This coverage is a group health plan and pays benefits for the treatment of an illness or injury. As you read about your coverage, keep the following in mind:

- The benefits described in this handbook apply only to the WM Build Your Own and EPO self-insured medical plan options
- WM offers the ability to save for future medical expenses through a health savings account (HSA), if you elect the high deductible health plan (HDHP)
- Cigna Behavioral Health provides the mental health and substance abuse coverage for the Build Your Own options
- In some locations, your options may include a stand-alone EPO
- For the Build Your Own and EPO options, Catamaran administers the prescription drug coverage
- In some locations, your options may include an HMO. If you are eligible for an HMO, separate materials provided by the HMO describe your benefits

How Your Medical Coverage Works

This section provides a brief overview of how your medical coverage works.

Coverage Choices

Depending on where you live, you have one or more of the following medical options available to you:

- Build Your Own (exclusive and non-exclusive)
- High deductible health plan (HDHP) with a health savings account (HSA)
- EPO (Exclusive Provider Organization)
- HMO
- Waive
- Out-of-Area

Please note: The EPO, HMO and Out-of-Area options are only offered in some areas. If these options are offered to you, information on that option is included on the enrollment site or by contacting the Benefit Center. For most HMOs, your prescription drug, mental health and substance abuse coverage is provided through the HMO. Coverage for these services under the Out-of-Area plan is administered by Catamaran and Cigna Behavioral Health. Coverage for these services under the EPO is administered by Catamaran and BCBS.

Choosing Whom to Cover

You may choose medical coverage for yourself; yourself and your spouse; yourself and one or more of your children; or yourself, your spouse and one or more of your children.

Please refer to the ***Participation*** section for details on who is eligible.

How Your Medical Options Pay Benefits

Depending on your medical plan option, different deductibles, coinsurance, out-of-pocket limits, and prescription drug options may apply. Following is a brief description of each feature of the medical options. This handbook does not explain HMO or Out of Area coverage. Please refer to mywmtotalrewards.com, or contact the Benefits Center for details regarding these options (if you are eligible for them).

Deductibles

The deductible is the amount you pay each year before the plan pays benefits.

The individual deductible applies separately to each covered individual, and the family deductible applies collectively to all covered persons in the same family. Once you meet the family deductible, your remaining covered family members do not have to meet their individual deductible amounts for the rest of the year. However, one covered family member cannot apply more than his or her individual deductible amount toward the family deductible.

Copayments

A copayment or copay is a flat dollar amount that you pay your provider (for certain services) before the plan pays benefits. If you build an option, the following copayments apply:

- $30 for an in-network primary care physician, OBGyn, or physical therapist office visit ($20 for a CCN doctor)
- $50 for an in-network specialist office visit ($40 for a CCN doctor)
- $30 for an in-network behavioral health or substance abuse visit
- For an emergency room visit (in- or out-of-network), $125 for first visit, $225 for second visit, $325 for any subsequent visits that occur in the same plan year; escalating copays apply to each family member separately
- $250 for in-network inpatient stays

For certain services, the plan may pay the full cost after you pay the copay.

Coinsurance

Coinsurance is the percentage of charges the plan pays after you meet any applicable deductible and/or copay requirement. The remaining percentage represents the amount you must pay.

Please note: If you participate in a non-exclusive Build Your Own option and you receive out-of-network services, the coinsurance percentage only applies to eligible services that do not exceed the maximum reimbursable charge (MRC). See *Eligible Charges* on page 30 for the definition of MRC. You are responsible for any amounts the plan does not cover, including any amounts that exceed the MRC.

Out-of-Pocket Limits

The out-of-pocket limit is the most you are required to pay in medical copays, deductibles and coinsurance in one year. Once you or your family, reach this limit, the plan pays 100% of the eligible charges (up to the MRC) for the rest of the year. Certain charges do not apply toward the limit, including:

- Prescription drug expenses
- Any expense that is above the eligible MRC or that exceeds the plan's limit
- Any ineligible services you pay for

Eligible Charges

If you participate in one of the medical options and receive in-network services, the plan pays benefits based on the negotiated fee for the service. The negotiated fee is the amount agreed to by the claim administrator (on behalf of the WM plan) and the provider.

If you participate in a non-exclusive Build Your Own option and receive care outside the network, the plan pays benefits based on maximum reimbursable charge (MRC). The MRC is the lowest of:

- The provider's normal charge for a similar service or supply
- 150% of a fee schedule using methodology similar to the methodology utilized by Medicare to determine the allowable fee for the same or similar service within the same geographic market

If you participate in an exclusive Build Your Own option or the EPO option, you must receive in-network services in order to receive benefits, so the MRC does not apply to you.

Medically Necessary and Appropriate

To be eligible for benefits, a service or supply must also be medically necessary and appropriate. Tests, treatments, services and supplies are medically necessary and appropriate for plan purposes if they are:

- Appropriate to diagnose or treat the symptoms of your condition, illness, disease or injury
- Provided to diagnose or treat your condition, illness, disease or injury
- Provided in accordance with good medical practice standards
- Not primarily for the convenience of your provider or you
- The most appropriate supply or service level that you can safely receive

If you are receiving inpatient care, "medically necessary and appropriate" also means that you require acute care due to the nature of your condition and that you cannot receive safe or adequate care on an outpatient basis.

Comparing Your Options

As long as you use network providers, the options pay in-network benefits. If you participate in a non-exclusive Build Your Own option, each time you need medical care, you can use an in-network provider or go outside the network for care. If you participate in an exclusive option (Build Your Own or EPO), you must use an in-network provider to receive benefits under the plan.

In-Network Medical Providers

With all options, you have access to a large network of physicians, specialists, hospitals and a variety of other treatment centers. You can receive care from a network provider of your choice, and you do not have to select a primary care physician (PCP).

All providers are thoroughly evaluated before they are accepted in the networks. To determine whether your provider participates in the network or to obtain the most up-to-date listing of hospitals and physicians who participate, go to mywmtotalrewards.com and use the Find A Doctor link. For the Build Your Own and HDHP options, you can also call WM's Dedicated Member Services Unit at Cigna at 800-545-6534 or log on to myCigna.com and select the link to the Provider Directory. (If you are prompted to select a network, choose Open Access Plus.) For the EPO option, you can also call 800-496-3907 or log on to bcbstx.com/wm and select Doctors & Hospitals.

Your ID card identifies you as a participant in a WM medical option. To receive in-network benefits, be sure to:

- Show your ID card to the hospital or other professional health care provider
- Ask the provider to file a claim on your behalf

If you do not show your ID card, you could be billed for the provider's normal charge.

Out-of-Network Medical Providers

If you are enrolled in a non-exclusive Build Your Own option and you receive services from a provider outside the network, you still receive benefits for eligible services. However, the plan pays benefits at a lower level. You are responsible for an annual deductible and a certain percentage of eligible expenses (coinsurance). You are also responsible for any difference between the provider's actual charge and the MRC.

If you are enrolled in an exclusive option (Build Your Own or EPO), you will not receive benefits under the plan if you receive services from a provider outside the network. Generally, the only exceptions to this are emergency medical services, or if you are using a network provider and that provider asks an out-of-network provider to assist with your care without your knowledge.

Emergency Medical Services

For emergency medical care to be reimbursed, the condition must be life threatening. The following conditions constitute a medically necessary, life-threatening emergency:

- The condition is severe
- The condition begins suddenly or unexpectedly
- Immediate treatment is necessary to avoid serious bodily injury or death

A life-threatening emergency may include a heart attack, stroke, severe bleeding or multiple broken bones. Situations that are not life threatening generally include colds, sore throats, ear aches and most insect bites.

In a life-threatening emergency, seek treatment immediately. If you experience a life-threatening emergency, coverage will be provided at in-network levels regardless of whether the provider is in the network.

Generally, you must call the claim administrator before you are admitted into a hospital. In the case of an emergency, contact the claim administrator within 48 hours or as soon as reasonably possible.

Out-of-Area Medical Coverage for Covered Dependents

If your covered dependent permanently resides outside of the network service area or is temporarily away from home, the medical plan pays benefits as follows:

- Eligible emergency care is covered at the in-network level, provided the situation is a true emergency
- For non-emergency care, your covered dependent must use an in-network provider to be eligible for in-network benefits. Dependents should schedule visits for eligible preventive services, including routine physical examinations, with an in-network physician while at home or if they reside in a network area, they should use the in-network providers in that area
- If you are enrolled in a non-exclusive option and your covered dependent receives services outside the network, the plan pays benefits at the out-of-network benefit level. If you are enrolled in an exclusive option (Build Your Own or EPO) and your covered dependent receives services outside the network, no benefits are provided under the plan

Medical Treatment Away From Home

If you are traveling and experience an urgent injury or illness, you should seek treatment from the nearest hospital, emergency room or clinic. If the illness or injury is a true emergency, benefits are paid at the in-network level. If the treatment results in a hospital admission, you have certain responsibilities under the precertification requirements. See ***Precertification*** section on page 51 for details.

If you are enrolled in a non-exclusive option and the illness or injury is not a true emergency and you receive care from an out-of-network provider, the plan pays benefits at the out-of-network benefit level. If you are enrolled in an exclusive option and the illness or injury is not a true emergency and you receive care from an out-of-network provider, the plan does not pay any benefits.

Inpatient Medical Admissions

You must contact your medical option claim administrator (Cigna at 800-545-6534 or BCBS at 800-496-3097) before all non-emergency inpatient admissions. For all emergency or maternity admissions, your in-network physician or hospital (or you, if out-of-network) must make this contact within 48 hours of admission. If you or your provider does not contact the claim administrator within the required timeframe, you may be charged a precertification penalty. If your admission is determined not to be medically necessary and appropriate, you are responsible for all facility charges.

Build Your Own Option

Choices Available

Under the Build Your Own option, you choose:

- ➤ Exclusive or non-exclusive plan
- ➤ Deductibles
- ➤ Coinsurance
- ➤ Out-of-pocket limits
- ➤ Prescription drug options

The following table shows your choices when you enroll in the Build Your Own option. Your choices are:

Choices:

1. Plan Type	Exclusive **In-Network**	Non-Exclusive **Out-of-Network***
2. Coinsurance	80% in-network after deductible OR 70% in-network after deductible	50% after deductible
3. Annual Deductible (Individual/Family)	$750 / $2,250 OR $1,000/ $3,000 OR $1,250 / $3,750	$2,500 / $7,500
4. Out-of-Pocket Limits (Individual/Family)	$4,250/ $8,500 OR $5,250/$10,500 OR $6,250 / $12,500	$9,000 / $18,000 $9,000 / $18,000 $9,000 / $18,000
5. Prescription Drug Program	Rx1 or Rx2	

* Not applicable if Exclusive plan-type chosen.

If you enroll in the Build Your Own option, you can choose one of the two prescription drug options described on the following page.

		Rx1 – Copay			Rx2 – Copay/Coinsurance		
		Good option if you take medications that do not have generic equivalents. Higher paycheck cost.			**Good option if you rarely use prescriptions or take mostly generics. Lower paycheck cost and generic copay.**		
		Generic	Preferred	Non-Preferred	Generic	Preferred	Non-Preferred
30-day supply	Walmart/Sam's	$5	$30	$60	$5	You pay 40% coinsurance $75 max	You pay 60% coinsurance $100 max
	Target/Kroger	$10	$35	$65	$7		
	Other Network Pharmacies	$15	$45	$75	$10		
90-day supply	Walmart/Sam's	$15	$90	$180	$15	You pay 40% coinsurance $225 max	You pay 60% coinsurance $300 max
	Target/Kroger	$30	$105	$195	$21		
	Home Delivery	$15	$90	$180	$15		
	Other Pharmacies	You will pay 100% of the cost.					

About Generics and Preferred Drug Lists (Formularies)
When you fill your prescription through a retail pharmacy, you automatically receive the generic equivalent (when available and permitted by law). However, you or your doctor may request that your prescription be filled with a brand-name medication. In this case, you are responsible for paying the difference between the brand-name and generic drug, in addition to any other copay/coinsurance amounts that apply.

The plan also has a list of preferred brand-name drugs that are covered. Your cost is less for a brand-name prescription drug that is listed on this preferred drug list (also called a formulary) than for a non-preferred brand name drug. You can get a copy of the formulary by going to **mywmtotalrewards.com** and choosing Pharmacy.

About Specialty Medications
Specialty medications are generally administered through injection or infusion, and treat rare or complex diseases that require clinical management. They can cost thousands of dollars per dose. WM's specialty pharmacy benefit helps make these drugs more affordable and is covered the same way under Rx1 and Rx2 options. (Note: Insulin is not considered a specialty medication.)

If you are prescribed a specialty medication, you only pay 10% of the cost, up to $110 for generic or preferred brand, and up to $160 for non-preferred brand medications. Your annual out-of-pocket maximum is $2,000. For more information about how to use this program, call **855-209-1293.**

Important Facts about Build Your Own Options

- The same medical services and supplies are covered (or excluded) under any option that you build. For example, any Build Your Own option includes preventive care and excludes hearing aids.
- Prescription drug benefits under all Build Your Own plans are administered by Catamaran.
- Because you can Build Your Own option, this summary does not show all of the variations. You should go online to build and compare these details. To access the Build Your Own option, go to the QuickLinks drop down menu and select mycatamaranrx.com. The formulary can be found under Forms and Documents. Be sure to build a few different plans so you can see the differences your choices make and their cost.

High Deductible Health Plan (HDHP) with Health Savings Account (HSA)

One of your medical plan options is the high deductible health plan (HDHP) with a health savings account (HSA). If you elect this option, the following benefits operate differently: Medical Benefits, Prescription Drug Coverage, and your Health Care Flexible Spending Account.

Medical Benefits under the HDHP

This section describes your medical benefits if you elect the HDHP. Please read this in conjunction with the rest of the "Medical Benefits" section for any other information.

Plan Type: Non-Exclusive	In-Network	Out-of-Network
Coinsurance	80% after deductible	50% after deductible
Annual Deductible Individual/Family	$1,500/$3,000	$3,000/$6,000
Out-of-Pocket Limit Individual/Family	$6,250/$12,500	$11,500/$23,000

Important Facts About the HDHP Option

- ➤ You are eligible to contribute to an HSA
- ➤ The same medical services and supplies are covered (or excluded) as those under the other Build Your Own options. For example, the HDHP option includes preventive care and excludes hearing aids. However, if you use a Lifesource Center for organ or tissue transplant, you must satisfy the annual deductible. Please refer to pages 40-50 for more information about the covered services and procedures
- ➤ All services and supplies (except for preventive care) are subject to the annual deductible. The deductible also applies to prescription drug benefits
- ➤ Copayments do not apply for any services or supplies (including doctor's office visits and prescription drugs). You pay the full cost for the services and supplies (minus any applicable Cigna discount) until you meet your deductible. After you meet the deductible, you pay your coinsurance amount (20%) until you reach your out-of-pocket maximum. After that, the plan pays 100% of covered expenses
- ➤ The high deductible prescription drug benefit described below applies
- ➤ Your prescription drug expenses count toward your annual out-of-pocket limit

High Deductible Prescription Drug Benefit

If you elect the HDHP, your prescription drug option will be a high deductible prescription drug benefit. Under the high deductible prescription drug benefit, the plan pays nothing until you satisfy your annual deductible. In other words, you will pay your entire prescription drug costs (less the plan discount) under the HDHP until you have satisfied the annual deductible, instead of having copayments. After you satisfy the annual deductible, you pay the applicable coinsurance amount (20%) until you reach the out-of-pocket maximums. After that, the plan pays 100% of covered expenses. The other rules for the prescription drug program also apply. See page 58 for more information on the prescription drug program.

Health Savings Account (HSA)

HSA Eligibility

If you choose the HDHP, you can have an HSA. The HSA is an individual savings account that lets you save, invest, and withdraw funds for qualified medical expenses on a tax-free basis. Qualified medical expenses include deductibles, coinsurance, and other out-of-pocket medical and prescription drug costs. Qualified medical expenses also include dental and vision expenses not covered by the plan or other insurance.

To be eligible for an HSA:

- Your only medical coverage must be a "high deductible health plan." If you enroll in the HDHP and do not have any other medical coverage, you satisfy this requirement; if you are also covered by a spouse's (or your own) PPO or other medical coverage, you do not meet this requirement
- You cannot be enrolled in Medicare
- You cannot be claimed as a dependent on someone else's tax return

To open an HSA, you must accept the terms and conditions associated with the HSA enrollment process.

HSA Contributions

Both WM and you may contribute to your HSA. The total contributions to your HSA for any year is limited by federal regulations. For 2014, this limit is $3,300 if you have single coverage or $6,550 if you have family coverage. For the purposes of your HSA, you have family coverage if you are enrolled in the HDHP along with at least one of your dependents who is a "dependent" under the federal tax rules. (In other words, you do not have family coverage for this purpose if your only enrolled dependent is your domestic partner who is not a dependent for federal income tax purposes.) If you are age 55 or older during the year, you can contribute an additional $1,000 to your HSA.

- **WM Contributions:** After you open your HSA, WM will contribute $500 to your HSA if you have single coverage or $1,000 if you cover at least one eligible dependent. WM will make these contributions in equal installments each pay period during the year. The annual WM contribution is pro-rated for partial-year enrollment.
- **Your Contributions:** You can make contributions to your HSA, up to the remainder of the legal limit ($2,800 or $5,550 in 2014 due to WM's contribution). If you elect to make pretax contributions, WM will deduct them from your pay and deposit them in your HSA. You may change your contribution election once a month. To make or change your HSA contribution election, call the Benefits Center at 800-964-3373.

  Instead of making payroll contributions, you can write a check to your HSA at JP Morgan Chase up to the remainder of the contribution limit. When you file your tax return for the year, you can deduct such a contribution.

  It is your responsibility to make sure that the contributions to your HSA do not exceed the legal limits. You will not be notified if you exceed the legal limits. You can monitor your year-to-date HSA contribution levels at any time by visiting myCigna.com or by calling 800-545-6534. If you have any questions, please consult with your tax advisor.

  You can withdraw excess HSA contributions, without a penalty, until April 15 of the following year. The excess contributions, if made pretax, and any associated pretax earnings must be included as income for the year in which they were made.

- **Investment of Contributions:** Once your HSA balance reaches $2,000, you can invest a portion of your balance in a variety of mutual funds with JPMorgan Chase. You can find information and prospectuses for the mutual funds on myCigna.com. For more information about investment options and rules for investing in them, log on to myCigna.com or call Cigna at 800-545-6534.

How the HSA Works

After you have elected the HDHP, you will receive a welcome kit that provides additional information about your HSA. To open your HSA, you must agree to the Terms and Conditions during the enrollment process. There are additional forms to complete, if you want a checkbook or additional debit cards.

There are a variety of fees that may be assessed against your HSA. For more information, log on to myCigna.com or call Cigna at 800-545-6534.

Using Your HSA

You may use your HSA:

- To pay for the qualified medical expenses of yourself or any of your dependents who are dependents for federal income tax purposes (meaning you can claim as a dependent on your federal income tax return). These dependents differ from the eligible dependents described on pages 6 and 7. Generally, you can claim your child as a federal tax dependent only if the child (1) is under the age 19 at the end of the tax year or under age 24 at the end of the tax year, if a full-time student; (2) resides in your household for more than half the taxable year and you provide over half of the child's financial support for the year and whose gross income does not exceed a specified amount; and 3) is not filing a joint tax return (with his or her spouse) for the same taxable year. Additionally, some of your relatives may be claimed as your federal tax dependent if certain conditions are met, such as you provide over half of the relative's financial support for the year and whose gross income does not exceed a specified amount.
- To save for future medical expenses. All amounts that you and WM contribute to your HSA are yours to keep even if you leave WM.
- To pay for non-medical-related expenses at any time. If you use your HSA to pay for non-medical-related expenses, you generally must pay income taxes on those amounts and a 20% penalty tax.

When you go to your Cigna network provider, present your Cigna ID card. Cigna network providers should not ask you to pay at the time of your visit. If you are asked to pay, show your provider the "Reminder Not to Collect" note on the back of your ID card. If you are billed at that time, ask your provider's office to call Cigna HealthCare at 800-545-6534.

After Cigna receives a bill from your provider, Cigna will send you an EOB, explaining what was covered and how much, if anything, you owe. Your provider will then send you a bill. You should check your HSA balance online, and decide whether you will pay the bill with your own money (if you are trying to save your HSA funds for later), or you can use your HSA debit card if you have enough money in your HSA. Either way, you must pay the bill you receive from your provider.

It is your responsibility to keep track of your deposits and expenditures and keep all of your receipts. Remember that your HSA may only be used to pay for your qualifying medical expenses or those of your federal income tax dependents that are only covered by a high deductible health plan. This means that you cannot use your HSA to pay medical expenses for your domestic partner who is not your federal income tax dependent or your spouse who is covered under another employer's medical plan that is not a high deductible health plan.

At the end of every year, any unused balance in your HSA will automatically roll over to the next year. There is no "use it or lose it" rule.

If You Leave Waste Management

If you leave WM for any reason, you keep your HSA – your contributions and WM's contributions. In that case, you can keep your HSA with JPMorgan Chase or move it to another HSA custodian.

If you die and your spouse (for federal income tax purposes) is your designated beneficiary, your spouse becomes the owner of your HSA and continues to receive the same tax benefits that were available to you. If you die and your designated beneficiary is not your spouse, that person will receive a taxable distribution of your account.

The HDHP and Your Flexible Health Care Spending Account

If you enroll in the HDHP, you can have both an HSA and a Health Care Flexible Spending Account, but the Health Care Flexible Spending Account must be a "Limited Use" Flexible Spending Account. This means your Flexible Spending Account only reimburses dental or vision expenses, as well as medical expenses not covered by the HDHP (e.g., over the counter supplies). All other rules regarding your Health Care Flexible Spending Account will continue to apply. For more information about the Health Care Flexible Spending Account, see page 126.

Exclusive Provider Organization (EPO)

The EPO is only offered in some areas. If it is offered to you, information will be available to you online during your enrollment.

Under the EPO, you must use an in-network provider to receive benefits. The plan will not pay for services from service providers that are outside the network except in the case of an emergency. The following table summarizes the key features of the EPO.

Plan Type	Exclusive In-Network
Coinsurance	80% in-network after deductible
Annual Deductible (Individual/Family)	$750 / $2,250
Out-of-Pocket Limits (Individual/Family)	$4,250 / $8,500

Prescription Drug Program

		Rx1 – Copay			Rx2 – Copay/Coinsurance		
		Good option if you take medications that do not have generic equivalents. Higher paycheck cost.			**Good option if you rarely use prescriptions or take mostly generics. Lower paycheck cost and generic copay.**		
		Generic	Preferred	Non-Preferred	Generic	Preferred	Non-Preferred
30-day supply	Walmart/Sam's	$5	$30	$60	$5	You pay 40% coinsurance $75 max	You pay 60% coinsurance $100 max
	Target/Kroger	$10	$35	$65	$7		
	Other Network Pharmacies	$15	$45	$75	$10		
90-day supply	Walmart/Sam's	$15	$90	$180	$15	You pay 40% coinsurance $225 max	You pay 60% coinsurance $300 max
	Target/Kroger	$30	$105	$195	$21		
	Home Delivery	$15	$90	$180	$15		
	Other Pharmacies	You will pay 100% of the cost.					

About Generics and Preferred Drug Lists (Formularies)
When you fill your prescription through a retail pharmacy, you automatically receive the generic equivalent (when available and permitted by law). However, you or your doctor may request that your prescription be filled with a brand-name medication. In this case, you are responsible for paying the difference between the brand-name and generic drug, in addition to any other copay/coinsurance amounts that apply.

The plan also has a list of preferred brand-name drugs that are covered. Your cost is less for a brand-name prescription drug that is listed on this preferred drug list (also called a formulary) than for a non-preferred brand name drug. You can get a copy of the formulary by going to **mywmtotalrewards.com** and choosing Pharmacy.

About Specialty Medications
Specialty medications are generally administered through injection or infusion, and treat rare or complex diseases that require clinical management. They can cost thousands of dollars per dose. WM's specialty pharmacy benefit helps make these drugs more affordable and is covered the same way under Rx1 and Rx2 options. (Note: Insulin is not considered a specialty medication.)

If you are prescribed a specialty medication, you only pay 10% of the cost, up to $110 for generic or preferred brand, and up to $160 for non-preferred brand medications. Your annual out-of-pocket maximum is $2,000. For more information about how to use this program, call **855-209-1293.**

Important Facts

- Your co-pays are:
  - For an office visit to an in-network primary care physician, OBGyn, or physical therapist, $20
  - For an in-network specialist office visit, $40
  - For an in-network behavioral health or substance abuse visit, $20
  - For an emergency room visit (in- or out-of-network), $125 for first visit, $225 for second visit, $325 for any subsequent visits that occur in the same plan year; escalating copays apply to each family member separately
  - For in-network inpatient hospital stay, $250
- The prescription drug benefits are administered by Catamaran. See ***Prescription Drugs*** on page 58.

What the Plan Options Cover – Build Your Own & EPO

The plan options pay benefits – up to the negotiated fee or the MRC – for medically necessary and appropriate expenses.

To receive plan benefits, any service performed must be medically necessary and appropriate.

Hospital

If an inpatient hospital admission is required, your admission must be precertified. See the ***Precertification*** section on page 51 for more information. The plan pays benefits for the following hospital-related services and supplies.

- Bed, board, and general nursing service in a:
  - Semi-private room (up to the semi-private room negotiated rate)
  - Private room (up to the semi-private room negotiated rate)
  - Special care unit that provides intensive care to the critically ill (up to negotiated rate)
- Operating, delivery, treatment rooms and equipment
- Prescribed drugs and medicines related to inpatient services (see the ***Prescription Drug*** section on page 58 for additional information on outpatient prescription drug benefits)
- Whole blood, administration of blood, blood processing and blood derivatives
- Anesthesia, anesthesia supplies and its administration
- Medical and surgical dressings, supplies, casts and splints
- Diagnostic services
- Therapy services
- Emergency accident care to treat traumatic bodily injury
- Emergency medical care to treat the initial sudden onset of an acute medical condition that requires prompt medical treatment
- Hospital services and supplies related to outpatient surgery
- Pre-admission testing

Surgical and Medical Services

The plan pays benefits for the surgical and medical services listed below.

- ➤ Surgical services, including pre- and post-surgical physician's visits
- ➤ Oral surgical services, including:
  - — The surgical removal of impacted teeth fully or partially covered by bone
  - — Stable implants in the upper or lower jaw when not done to prepare the mouth for dentures
  - — Frenectomy of the upper or lower jaw
- ➤ Charges made for surgical and nonsurgical care for TMJ and related care, which includes care for: (a) Temporomandibular Joint and Craniomandibular Joint Disorders; and (b) other conditions of the joints linking the jawbone and skull, including the complex of muscles, nerves and other tissues related to that joint
  - — This does not include (i) appliances (ii) devices or (Iii) dental work, such as, but not limited to orthodontics, fixed or removable bridgework/dentures, inlays, onlays, crowns or equilibrations, whether done for dental or medical reasons
- ➤ Surgical assistant – If a house staff member, intern or resident is not available – provided the person is a physician and helps the surgeon perform the covered surgery
- ➤ Administration of anesthesia, provided it is rendered by a professional provider who is not the surgeon or the surgical assistant
- ➤ Second surgical opinions
- ➤ Inpatient medical services for a condition not related to surgery, pregnancy, or mental illness, including:
  - — Medical care visits
  - — Intensive medical care when your condition requires it for a prolonged time
  - — Concurrent care rendered by a provider who is not your surgeon while you are hospitalized for surgery, or rendered by two or more providers during one hospital stay
- ↗ Consultation by another professional provider provided the attending provider requests such consultation
- ↗ Emergency services, including:
  - — Emergency accident care to treat an accidental bodily injury
  - — Emergency medical care to treat a sudden and acute medical condition
- ↗ Mastectomy
- ↗ Reconstructive breast surgery performed within six years of a medically necessary mastectomy, including:
  - — Reconstruction of the breast on which the mastectomy was performed
  - — Surgery and reconstruction of the other breast to produce a symmetrical appearance
  - — Prosthesis and physical complications for all stages of the mastectomy, including lymphedemas
- ➤ One home health care visit within 48 hours after discharge, provided the discharge occurs within 48 hours after an admission and the admission is related to a mastectomy

If more than one surgical procedure is performed during the same operative session through the same incision or body opening, the plan pays benefits according to the following multiple surgery guidelines:

- The benefit provided for the most expensive surgery is determined under the plan's regular rules
- The benefit provided for the surgery(ies) with the lower charge(s) is reduced by 50%

Office Visits

Unless you elected the HDHP, the plan provides 100% coverage (after your copayment) for medical professional services associated with office visits that are not related to surgery or pregnancy. If you elect the HDHP, your deductible and coinsurance amounts apply to these services.

Adult Preventive Care

The plan provides 100% coverage (no copayment or deductible required) for the preventive care services required by the federal health care reform law, when provided in-network. A list of all the preventive care services can be found at healthcare.gov. Examples of such preventive care services include:

- Annual routine well-woman gynecological exams and services, including:
  - Mammogram
  - Pelvic exam
  - Breast exam
  - Pap test
  - Other preventive care and screenings for women, as recommended by the Health Resources and Services Administration
- Annual routine history and physical examination, including:
  - Medical history
  - Height and weight measurement
  - Physical examination
  - CBC (complete blood count)
  - Baseline EKG, age 50 and over
  - Cholesterol screening
- Routine vision exam
- Fecal occult blood test (annually after age 50)
- Blood lipids screening
- Prostate Specific Antigen Test (PSA) (annually after age 40)
- Tetanus, Diphtheria, Pertussis vaccine
- Flexible sigmoidoscopy and a colonoscopy, after age 50
- Measles, mumps, and rubella (MMR) vaccine
- Varicella vaccine
- Meningitis immunization
- Hepatitis A and B series immunization
- Influenza vaccine
- Pneumococcal vaccine
- Human Papillomavirus vaccine (3 doses)
- Other immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention

Pediatric Preventive Care

For dependent children, the plan provides 100% coverage (no copayment or deductible required) for certain preventive care services as required by the federal health care reform law, when provided in-network. A list of all the preventive care services can be found at healthcare.gov. Examples of such preventive care services include:

- Pediatric immunizations (including those recommended for children by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention)
- Routine history and physical examination, including:
  - Medical history
  - Height and weight measurement
  - Physical examination
  - Counseling, where appropriate
- Rotavirus vaccine
- Hepatitis B vaccine

Women's Preventive Care

For women, the plan provides 100% coverage (no copayment or deductible required) for certain preventive care services as required by the federal health care reform law, when provided in-network. A list of all the preventive care services can be found at healthcare.gov. Examples of such preventive care services include:

- Annual well-woman preventive care visits, including preconception and certain prenatal care
- Screening for gestational diabetes
- HPV testing for women over 30, no more than once every three years
- Annual counseling on sexually transmitted infections for all sexually active women
- Annual counseling and screening for HIV
- Breastfeeding support and counseling, including the cost of renting breastfeeding equipment
- Annual screening and counseling for interpersonal and domestic violence
- Prescribed FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity

Diagnostic Services

The plan pays benefits for the following diagnostic services:

- X-rays, including:
  - Radiology
  - Magnetic resonance imaging (MRI)
  - Ultrasound
  - Nuclear medicine
- Pathology, including laboratory and pathology tests
- Mammogram
- Diagnostic medical procedures, including:
  - Electrocardiograms (ECGs)
  - Electroencephalograms (EEGs)
  - Physiological medical testing
  - Other electronic diagnostic medical testing procedures
- Allergy testing, including:
  - Percutaneous
  - Intracutaneous
  - Patch tests
- Second opinions

Outpatient Rehabilitative Therapy Services

The plan covers medically necessary therapy provided by a professional, including:

- Radiation therapy
- Dialysis treatment
- Respiration therapy
- Chemotherapy
- Speech therapy (including developmental delay)
- Physical therapy (including developmental delay)
- Occupational therapy (including developmental delay)

The plan also covers home infusion therapy services, including:

- Pharmaceuticals
- Intravenous solutions
- Pharmacy services
- Medical/surgical supplies
- Nursing services associated with home infusion therapy

Developmental Delay

The plan will cover medically necessary therapy provided by a professional for developmental delay. Developmental delay is slowed or impaired development of a child, which is likely to result in long-term limitations in functional abilities in learning, language, social-emotional skills and/or mobility. Physical, occupational and speech therapy for developmental delay conditions is covered up to 100 visits per calendar year for all therapies combined. Speech therapy for these conditions is only covered through age five. Group speech therapy is not covered.

Rehabilitation services are only covered if they are performed by a licensed therapy provider, under the direction of a physician. Coverage for rehabilitation services will not include services that have not demonstrated continuous improvement. Benefits will not be provided for a treatment:

- After it is no longer therapeutic
- If it is determined not medically necessary
- If it is administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring

Maternity Care

The plan pays benefits for the following pregnancy-related services:

- Normal pregnancy
- Miscarriage or therapeutic abortion
- Newborn care while the mother is an inpatient
- Complications of pregnancy
- Nursery care

The plan does not pay benefits for surrogate mothers where the mother receives a medical service or obtains a medical supply for purposes of generating a profit, fee or other compensation. A surrogate mother is a woman who agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

As required by federal law, the plan does not limit childbirth-related hospital stays for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. In addition, the plan does not require a provider to receive authorization for any length of stay that is less than these periods. However, federal law and the plan generally do not prohibit the mother’s or newborn’s attending health care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Family Planning

The plan pays benefits for the following family planning services:

- Office visits, tests and counseling
- Contraceptive devices (e.g., Depo-Provera, Norplant, intrauterine devices and diaphragms if services are provided in physician's office)
- Surgical sterilization procedures for vasectomy or tubal ligations (excluding reversals)

Home Health Care/Private Duty Nursing

The Plan pays benefits for the following home health care/private duty nursing services:

- Skilled nursing care provided by or supervised by a registered graduate nurse (RN) or a licensed practical nurse (LPN) including:
  - Prescribed drugs
  - Medical social service consultations
  - Medical and surgical supplies
  - Oxygen and its administration
  - Health aide services provided you are also receiving covered nursing or therapy services
  - Outpatient private duty nursing
- Bereavement counseling (inpatient and outpatient)

The plan does not pay home health care/private duty nursing benefits for:

- Dietician services
- Homemaker services
- Maintenance therapy
- Dialysis treatment
- The purchase or rental of dialysis equipment
- Custodial care
- Food or home-delivered meals

Skilled Nursing Facility

If your physician places you in a skilled nursing facility, the plan pays benefits for the following services:

- Room and board, up to the facility's semi-private room rate
- Other related services and supplies

The plan does not pay skilled nursing facility benefits:

- Once you can no longer benefit from treatment
- For custodial care, or care for someone's convenience
- For the treatment of alcohol abuse, drug abuse or mental illness

Hospice Care Services

Hospice care is a special type of care for terminally ill patients. The plan pays benefits for hospice care provided in an inpatient hospice facility or in the patient's home.

Human Organ or Tissue Transplant Services

The plan pays for human organ or tissue transplant services, including the removal of an organ or tissue from a donor when the donor is not covered under any health care plan. To be covered under the plan, transplant services must be provided by a network provider.

Other Covered Services

The plan pays benefits for a variety of other medically necessary and appropriate services. (See the benefit comparison chart for your medical plan option by going to mywmtotalrewards.com for the percentage the plan pays as well as any limits that apply.)

- Ambulance services, including local transportation by a vehicle equipped to transport the sick or injured:
  - From your home, scene of an accident or medical emergency to a hospital
  - Between hospitals
  - Between a hospital and a skilled nursing facility
  - From a hospital to your home
  - From a skilled nursing facility to your home

  Trips must be to the closest local facility that can provide services appropriate for the condition. If this is not possible, the plan pays benefits for trips to the closest facility outside your local area
- Chiropractic services (spinal manipulation)
- Dental services for accidental injury to the:
  - Jaw
  - Sound natural teeth
  - Mouth
  - Face

  Charges must be for a continuous course of dental treatment that starts within six months of the injury. Injuries caused by chewing and biting are not accidental injuries
- Diabetes education as an ambulatory patient, when prescribed by a physician and provided by an approved outpatient diabetes education program, including:
  - The initial assessment and education, up to four outpatient visits during a calendar year (these four visits will be provided once during your lifetime)
  - Post-education assessment and review, up to two outpatient visits during the same calendar year
  - Follow-up education to refresh existing knowledge and to present appropriate diabetes management techniques, up to two subsequent outpatient visits per calendar year
- Durable medical equipment (rental, purchase, adjustment, repairs, or replacement of), when prescribed by a professional. The cost to rent must not be more than the purchase price
- Orthotic devices, which include rigid supportive devices that restrict or eliminate motion of a weak or diseased body part, including purchase, fitting, necessary adjustment, and repair and replacement
- Prosthetic appliances, which include supplies that replace all or part of a missing body organ and its adjoining tissues, or that replace the function of a permanently useless or malfunctioning body organ, including purchase, fitting, necessary adjustment, and repair and replacement. The plan only covers external prosthetic appliances that are determined by the claim administrator to be the most appropriate and cost effective alternative available. To determine if the external prosthetic appliance you are considering is covered, call the claim administrator
- Wigs for the condition of Alopecia and cancer treatment (maximum of one per year)

Behavioral Health

The plan pays benefits for mental health and substance (drug/alcohol) abuse treatment. The mental health and substance abuse coverage only provides benefits for inpatient facilities that are licensed by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or an appropriate state licensing board, and that have 24-hour nursing and an onsite psychiatrist.

This mental health and substance abuse coverage does not cover wilderness camps, military schools, and educational and academic testing and services.

Mental Health Services

All inpatient and partial hospitalizations for mental health treatments must be approved and precertified by Cigna Behavioral Health (or BCBS if you participate in the EPO) before the plan will pay benefits. For covered inpatient services, the applicable copays, coinsurance, deductibles and out-of-pocket limits of your medical plan option apply. The following are covered inpatient services:

- Inpatient facility services
- Inpatient services, including individual psychotherapy, group psychotherapy, psychological testing, counseling with family members to aid your diagnosis and treatment, and electroshock treatment or convulsive drug therapy
- Partial hospitalization mental health services, and residential and day treatment programs
- Intensive outpatient or structured outpatient program services

Outpatient mental health services, including those provided by a hospital, other facility, or a professional provider are also covered under the plan. In-network mental health office visits are subject to the primary care physician copayment (or deductible and coinsurance under the HDHP).

Substance Abuse Services

All inpatient and partial hospitalizations for substance abuse treatments must be precertified by Cigna Behavioral Health (or BCBS if you participate in the EPO) before the plan will pay benefits. For covered inpatient services, the applicable copays, coinsurance, deductibles and out-of-pocket limits of your medical plan option apply. The following are covered inpatient services:

- Inpatient detoxification
- Inpatient or residential rehabilitation
- Residential, partial hospitalization and day treatment services
- Intensive outpatient or structured outpatient program services

Outpatient substance abuse services, including individual psychotherapy, group psychotherapy, psychological testing, counseling with family members to aid your diagnosis and treatment, provided by a hospital, other facility or a professional provider are also covered under this plan. In-network substance abuse office visits are subject to the primary care physician copay (or deductible and coinsurance under the HDHP).

A course of substance abuse rehabilitation treatment is considered completed and ends after 90 days from the last date authorized by Cigna Behavioral Health (or BCBS if you participate in the EPO) for the same diagnosis.

A participant who leaves treatment prematurely is considered to have completed that course of treatment after 90 days from the last date authorized by Cigna Behavioral Health (or BCBS if you participate in the EPO) for the same diagnosis. A course of treatment shall be considered completed if a patient has completed primary treatment and is in continuing care but discontinues treatment for more than 90 days or discontinues primary treatment for more than 90 days.

Medical Expenses Not Covered

The plan does not pay benefits for the following:

- Services or supplies that are:
  - Not prescribed or performed by a physician or other professional provider
  - Received from a dental or medical department sponsored by or for an employer mutual benefit association, labor union, trust, or any similar group or person
  - Received from a provider who is a member of your (or your covered dependent's) immediate family
  - Received before your (or your dependent's) coverage effective date
  - Behavioral health (mental health and substance abuse) in nature but not rendered by a behavioral health provider
  - Any inpatient behavioral health treatment not precertified by the claim administrator
  - Provided to a person for a procedure which results in the person being paid a fee, compensation or such person otherwise profits from such procedure or supply, including but not limited to, medical expenses relating to donation of plasma in exchange for a fee or medical expenses relating to a participant's decision to carry a child for the benefit of another person in exchange for a fee (surrogacy).
- Services or supplies that are not medically necessary or appropriate. Medically necessary or appropriate means services or supplies provided by a physician or hospital that the plan determines are:
  - Appropriate for the symptoms and diagnosis or treatment of the condition, illness, disease or injury
  - Provided for the diagnosis, or the direct care and treatment of the condition, illness, disease or injury
  - In accordance with standards of good medical practice
  - Not primarily for the convenience of the patient or the provider
  - The most appropriate supply or level of service that can safely be provided. When applied to hospitalization, this further means that the patient requires acute care as an inpatient due to the nature of the services rendered or the patient's condition, and the patient cannot receive safe or adequate care as an outpatient
- Experimental or investigative treatments, services, procedures, facilities, equipment, drugs, devices or supplies that the plan determines are not medically effective or necessary for the condition being treated Experimental or investigative procedures are those that:
  - Do not have FDA approval
  - Have not been proven effective
  - Are not proven to be as safe, as effective, or more effective than alternative therapies
  - Do not improve health
  - Are not applicable outside a research setting
- Services or supplies received after your coverage terminates
- Illnesses or injuries that:
  - Are related to your employment, provided workers' compensation benefits are available
  - Occur as a result of or in any act of war
- Charges that you are not legally obligated to pay in the absence of this or a similar coverage
- Services or supplies payable under Medicare when Medicare is primary, or services or supplies eligible for payment under Medicare if you had applied for Medicare and claimed Medicare benefits (unless the plan is obligated to offer you these benefits and this plan is primary)
- Deductibles and/or coinsurance amounts required under Medicare or any Medicare supplemental coverage
- Services or supplies that are provided to you as a member of the armed forces, the National Health Service or a Veterans Administration facility for a service-connected illness, unless you have a legal obligation to pay
- Injuries resulting from the maintenance or use of a motor vehicle, if such injuries are covered under a motor vehicle insurance policy

- Charges submitted by two professional providers for the same services performed on the same date for the same patient
- Services performed by a professional provider enrolled in an education or training program, when such services are related to the education or training program
- Cosmetic surgery and related services that are intended to improve the appearance of any portion of the body but not physiological function. Unless specifically excluded elsewhere, the plan pays benefits when cosmetic surgery is necessary to correct conditions that result from an accidental injury or disease that occurs while covered under the plan, or reconstructive surgery following surgery. For example, abdominoplasty and panculectomy are specifically excluded elsewhere (see page 50) so they are not covered regardless of the reason for the surgery
- Telephone consultations
- Charges associated with failing to keep a scheduled visit, or for failing to complete claim forms
- Personal hygiene and convenience items, including:
  - Radio/television rentals
  - Air conditioners
  - Humidifiers
  - Physical fitness equipment
  - Haircuts, shampoos and sets
  - Guest meals
  - Elevators, lifts or “barrier-free” home modifications
  - Stair glides
- Inpatient admissions that are primarily for diagnostic studies
- Custodial care, domiciliary care or rest cures
- Respite care
- Foot care (except some joint, ligament, and bone surgery), care to relieve foot pain or cosmetic foot care, including:
  - Flat foot conditions
  - Supportive devices for the foot
  - Treatment of subluxations of the foot
  - Care of corns
  - Bunions (except capsular or bone surgery)
  - Calluses
  - Toenails
  - Fallen arches
  - Weak feet
  - Chronic foot strain
  - Symptomatic complaints of the feet
- Well-baby care and immunizations, except as described in this handbook
- Unapproved tests performed without a certificate of need on high-cost technological equipment, including:
  - Computed tomography (CT) scanners
  - Lithotriptors
  - Magnetic resonance imaging (MRI) scanners
- Care, filling, removal, or replacement of teeth, and treatment of injuries to or diseases of the teeth, gums, or structures directly supporting or attached to the teeth, including:
  - Apicectomy (dental root resection)
  - Root canal treatments
  - Soft tissue impactions
  - Injury caused by chewing or biting
  - Alveolectomy and treatment of periodontal disease, except orthodontic treatment for congenital cleft palates
- Oral surgery, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face
- Dentistry or dental processes, other than those specifically described in this handbook
- Hearing aids, tinnitus maskers, or examination for the prescription or fitting of hearing aids
- Treatments leading to or in connection with transsexual surgery

- Infertility treatment, including testing to determine cause of infertility and treatment performed to restore fertility
- Assisted fertilization techniques, including:
  - Artificial insemination
  - In vitro fertilization (IVF)
  - Gamete intrafallopian transfer (GIFT)
  - Zygote intrafallopian transfer (ZIFT)
  - Any method used to enhance the possibility of conception through retrieval or manipulation of the sperm or ovum
- Examination for prescribing and fitting of eyeglasses or contact lenses (except when required following a cataract operation, for aphasic patients, soft lenses, or sclera shells intended to treat a disease or injury)
- Correction of myopia or hyperopia through corneal microsurgery, including:
  - Keratomileusis
  - Keratophakia
  - Radial keratotomy
- Treatment of obesity, except surgical treatment of morbid obesity when medically necessary and appropriate due to the patient's weight, and when other medically appropriate treatments have been tried unsuccessfully
- Nutritional counseling and services intended to produce weight loss
- Dietary or food supplements
- Abdominoplasty and pannculectomy
- Screening examinations, including X-ray exams, made without film (except for mammograms)
- Acupuncture
- Treatment of sexual dysfunction (including but not limited to erectile dysfunction) not related to organic disease or injury
- Transsexual surgery and related services
- Reversal of voluntary sterilization procedures
- Care that extends beyond traditional medical management, or for inpatient confinement for conditions related to:
  - Conduct disorders
  - Mental retardation
- V codes, as described in the Diagnostic and Statistical Manual of Mental Disorders
- Wilderness camps, military schools, and educational and academic testing and services
- Treatments that are educational and/or training in nature (including biofeedback)
- Providers' charges in excess of the MRC
- Services for which any governmental program or unit provides benefits
- Routine or periodic physical examinations, except as described in this handbook
- Expenses incurred outside the United States or Canada, unless you or your dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure
- Any other medical or dental service or treatment, except as described in this handbook

Medical Management Program

Precertification

All medical options have certain precertification requirements to help ensure that you receive medically necessary and appropriate treatment. For the services described below, you must call the claim administrator before you receive them to authorize your care and confirm that it is eligible for medical coverage. If you do not, benefits will be reduced. If a service is not medically necessary and appropriate, you are responsible for all charges.

You must precertify the following inpatient admissions:

- Hospital
- Rehabilitation hospital

If you participate in a non-exclusive Build Your Own option, you must precertify any of the following provided by an out-of-network provider:

- Magnetic Resonance Imaging (MRI)
- Computed Axial Tomography scan (CAT scan)
- Positron Emission Tomography scan (PET scan)

You must call Cigna Behavioral Health at 800-862-3558 (or, if you participate in the EPO, call BCBS at 800-496-3907) before you receive any inpatient behavioral health treatment to authorize your care and confirm that the services are covered. You must precertify all inpatient treatment. Examples include:

- Alcohol or drug abuse detoxification or treatment center
- Psychiatric hospital or treatment center
- Partial hospitalization program
- Residential treatment program

If you fail to request precertification, a penalty applies. In addition, if the treatment is determined not to be medically necessary, you are responsible for all charges.

Non-Emergency Admissions

For all non-emergency admissions, you, your dependent or the attending physician must contact the claim administrator beforehand to determine whether the care and setting are appropriate. Where alternative services are more appropriate, alternatives will be discussed.

If you do not precertify a medical non-emergency admission, a penalty applies. Additionally, if a non-emergency admission is determined not to be medically necessary, you are responsible for all facility charges. For behavioral health, all inpatient and partial hospitalizations (including residential treatment programs) require precertification. Failure to precertify will result in denial of the claim.

Emergency/Maternity Admissions

You must notify the claim administrator within 48 hours or as soon as reasonably possible of all emergency and maternity admissions and provide any required information concerning the admission. If you do not, a penalty applies. If an emergency or maternity admission is determined not to be medically necessary and appropriate, you are responsible for all facility charges.

Continued Stay Review

While you or a covered dependent is in a facility, each case is reviewed by a professional to make sure that continued treatment is appropriate. If the continued stay is determined not to be medically necessary, plans are discussed for a continued course of treatment in a more appropriate health care setting. If you or your covered dependent elects to stay in the facility after the date established, the plan will not pay benefits for the remainder of the stay.

Medical Case Management

When a catastrophic illness, injury or chronic medical condition occurs, you or your covered dependent may need certain medical services and supplies that are not covered under your medical plan. The plan may provide or approve any service, supply, equipment or benefit, however, that otherwise would not be covered if:

- ➤ Your or your covered dependent's condition could benefit from case management intervention
- ➤ Such services, supplies, equipment, or benefits are determined medically necessary and to be an acceptable cost-effective treatment alternative
- ➤ The cost of these services does not exceed the cost of benefits you would otherwise receive from the plan

Applying for Benefits

Depending on whether you receive in- or out-of-network services, you may not have to file a claim before the plan pays benefits.

Do You Need to File Claims?

The table below shows who needs to file claims for benefits.

If You…	Do You Need to File a Claim?
Receive in-network services	No
Receive out-of-network services (applies to non-exclusive plans or emergency claims for exclusive plans)	Yes, unless your out-of-network provider submits the claim on your behalf

Filing a Medical Claim

These procedures apply to claims under the medical coverage (including behavioral health and prescription drug), which are all referred to as "medical benefit" claims. The Administrative Committee of the Waste Management Employee Benefit Plan has the authority to decide whether an individual is eligible to participate in the plan. A claim administrator has the authority to decide the level of benefits that are available to an individual. Please refer to page 22 of the ***Participation*** section for more information on eligibility and enrollment claims.

Initial Claim Decision

When a claim is received for a medical benefit, the claim administrator must decide whether (or at what level) the medical benefit is covered under the plan. When the medical benefit is provided or denied, you will receive a notice explaining how the coverage level was calculated or why benefits have been denied. How fast this notice must be given to you depends on whether the claim is an urgent care claim, a pre-service claim or a post-service claim. The deadline for this notice is no later than:

- For an urgent care claim, 72 hours after the claim is received
- For a pre-service claim, 15 days after the claim is received
- For a post-service claim, 30 days after the claim is received

The following rules apply if your claim is an urgent care claim or a pre-service claim:

- You will be notified of the decision whether or not it is adverse
- You can be notified of an initial decision orally, if a written or electronic notice is provided no more than three days after the oral notice

Failure to Follow Urgent Care or Pre-Service Claims Procedures

If you fail to follow the procedures for filing an urgent care claim or a pre-service claim, you will be notified of the failure and the proper procedure to be followed. This notice must be provided to you no later than 24 hours after the failure for urgent care claims or five days after the failure for pre-service claims. This notice may be oral unless you (or your representative) request a written notice. This notice is triggered when:

- You (or your representative) make a communication that is received by a person or organization unit customarily responsible for handling benefit matters and
- The communication names a specific participant or covered dependent, a specific medical condition and a specific treatment, service or product for which approval is requested

Notice of Incomplete Urgent Care Claim

If you (or your representative) properly submit an urgent care claim that is missing necessary information, you will receive a notice. This notice will tell you the specific information needed to complete the claim. The notice will be given to you no later than 24 hours after receiving the claim. You must be given a reasonable time to provide the information but not less than 48 hours. You will be notified of the decision concerning your urgent care claim as soon as possible but no later than 48 hours after the earlier of:

- When the plan receives the requested information or
- The end of the period you were given to provide the information

Concurrent Care Claim

At times, the claim administrator may approve a course of treatment that is provided over time or for a specific number of treatments. If the claim administrator later terminates or reduces approval for a course of treatment, it will notify you of this decision so you will have sufficient time to appeal that decision before the course of treatment is reduced or terminated.

If you need to extend a course of treatment and the original request for the treatment was an urgent care claim, you should contact the claim administrator at least 24 hours before the approved course of treatment will expire. If you do so, the claim administrator will provide you with a notice of its decision concerning the requested extension within 24 hours of your request. If you request an extension later, you will receive notice of the claim administrator's decision based on whether that request is an urgent care or pre-service claim.

Appealing a Denial

If you disagree with an adverse determination, you may request a full review by the claim administrator. You must submit this request within 180 days after you receive the adverse determination. A rescission of coverage is treated as an adverse determination and may be appealed. In connection with your appeal, you or your representative can review relevant documents and submit issues and comments in writing. See page 22 for more information concerning relevant documents. If you want to appeal a benefit decision, send your appeal to the claim administrator listed in the ***Administrative Information*** section of this handbook.

Your appeal will be reviewed and someone other than the person who made the first decision on your claim must make this review. The claim administrator must disclose the identity of any medical or vocational experts who were consulted in connection with your claim. If the benefit decision is based on a medical judgment, the claim administrator must consult with a health care professional who has the appropriate training and experience in the field of medicine involved.

If the claim administrator considers or relies upon any new or additional evidence in making the benefit decision, you will be provided with this evidence, free of charge, as soon as possible and sufficiently in advance of the date the decision is made. If the claim administrator bases the benefit decision on any new or additional rationale, you will be provided with this rationale, free of charge, as soon as possible and sufficiently in advance of the date the decision is made.

After a decision is made concerning your appeal, you will be notified of its findings and decision in writing. This notice will be provided no later than:

- For an urgent care claim, 72 hours after receiving the appeal
- For a pre-service claim, 30 days after receiving the appeal
- For a post-service claim, 60 days after receiving the appeal

Claims Decisions Notices

The notice given to you concerning the decision on either your initial claim or your appeal will include:

- The specific reason or reasons for the decision
- The specific plan provisions upon which the benefit decision is based
- The denial code and its corresponding meaning, as well as a description of the plan's standard, if any, used in the decision
- Information sufficient to identify the claim involved, including the date of service, health care provider, a notice regarding the availability of the diagnosis and treatment codes and their corresponding meanings, upon request, and claim amount (if applicable)
- A description of any additional material or information that is necessary for you to complete your claim and an explanation of why such material or information is necessary
- If an internal rule, guideline, protocol or similar criterion was relied on in making the decision, either a copy of that document, or a statement that such a document was relied upon and that a copy will be furnished (free of charge) upon request
- If the decision is based on a medical limit (for example, a decision that the proposed service is not medically necessary or that it is experimental), either an explanation of the scientific or clinical judgment for the decision (applying the plan's terms to your medical circumstances), or a statement that such an explanation will be provided free of charge upon request
- A statement disclosing the availability of, and contact information for, any applicable consumer assistance office or ombudsman established to assist individuals with claims and appeals and the external review process
- For an initial claim, a description of the appeal procedures
- For an appeal, a description of the external review procedures

- For an appeal, a statement describing your right to bring a civil action under section 502(a) of ERISA following the denial of your appeal

External Review Procedures

If you disagree with the decision concerning your appeal, you may be eligible to request an external review of your claim. To be eligible for an external review, you must:

- Have been covered under the plan when the service was requested/provided
- Exhausted the plan's claims and appeals procedures, described above
- Have a claim that relates to a question of medical judgment or a rescission of coverage, and
- Have provided all information and documentation required to process external review

If you are eligible to file a request for external review, you must send your request to the claim administrator listed in the Administrative Information section of this handbook within four months of receiving the adverse decision concerning your appeal. The external review will be assigned to an independent review organization (IRO). If you believe an expedited external review is necessary to avoid jeopardizing your life or health, you must file a request for an expedited review with the claim administrator.

How to File Claims

For all medical claims (other than for behavioral health and prescription drugs), mail your completed claim form (along with the supporting original bills) to the address on the claim form. The form must be signed and dated.

Be sure to include the:

- Provider's name and address
- Patient's full name
- Date of service
- Description of the service or supply
- Amount charged
- Diagnosis or nature of illness
- The doctor's certification (for durable medical equipment)
- The nurse's license number and shift worked (for private duty nursing)
- Total mileage (for ambulance services)

If you already paid for services, you must also submit proof of payment (receipt from provider) with your claim form. Make copies of all bills for your records because original bills will not be returned to you.

Medical claim forms are available by contacting the claim administrator or by logging on to mywmtotalrewards.com, and selecting the link to the claim administrator's website. Medical claims should be sent to the address on the back of your ID card.

Claim Filing Deadline

You have up to one year from the date services or supplies are provided to file your claim for benefits. Claims filed after one year are not eligible for benefits.

Exhaustion of Administrative Remedies

You must exhaust all administrative remedies in this section (with the exception of the external review procedures) before you may bring a civil action following a denial of benefits. In any event, your civil action must be brought within two years from the date the claim was first filed.

Prescription Drug

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If you enroll in a Build Your Own, EPO or Out-of-Area option, you are eligible for the prescription drug benefits administered by Catamaran. This program enables you to purchase prescription drugs at a participating retail pharmacy or through the Walmart Home Delivery service. The program is to be used for all outpatient prescriptions.

If you select an HMO option or you decline medical coverage (the Waive option), you are not eligible for prescription drug benefits through this program. If you select the HDHP with a HSA option, see page 35 for details regarding your prescription drug coverage.

A Snapshot of the Prescription Drug Program

All of the prescription drug benefit programs include the retail and Home Delivery service components.

		Rx1 – Copay			**Rx2 – Copay/Coinsurance**		
		Good option if you take medications that do not have generic equivalents. Higher paycheck cost.			**Good option if you rarely use prescriptions or take mostly generics. Lower paycheck cost and generic copay.**		
		Generic	Preferred	Non-Preferred	Generic	Preferred	Non-Preferred
30-day supply	Walmart/Sam's	$5	$30	$60	$5	You pay 40% coinsurance $75 max	You pay 60% coinsurance $100 max
	Target/Kroger	$10	$35	$65	$7		
	Other Network Pharmacies	$15	$45	$75	$10		
90-day supply	Walmart/Sam's	$15	$90	$180	$15	You pay 40% coinsurance $225 max	You pay 60% coinsurance $300 max
	Target/Kroger	$30	$105	$195	$21		
	Home Delivery	$15	$90	$180	$15		
	Other Pharmacies	You will pay 100% of the cost.					

About Generics and Preferred Drug Lists (Formularies)
When you fill your prescription through a retail pharmacy, you automatically receive the generic equivalent (when available and permitted by law). However, you or your doctor may request that your prescription be filled with a brand-name medication. In this case, you are responsible for paying the difference between the brand-name and generic drug, in addition to any other copay/coinsurance amounts that apply.

The plan also has a list of preferred brand-name drugs that are covered. Your cost is less for a brand-name prescription drug that is listed on this preferred drug list (also called a formulary) than for a non-preferred brand name drug. You can get a copy of the formulary by going to **mywmtotalrewards.com** and clicking the Pharmacy link.

About Specialty Medications
Specialty medications are generally administered through injection or infusion, and treat rare or complex diseases that require clinical management. They can cost thousands of dollars per dose. WM's specialty pharmacy benefit helps make these drugs more affordable and is covered the same way under Rx1 and Rx2 options. (Note: Insulin is not considered a specialty medication.)

If you are prescribed a specialty medication, you only pay 10% of the cost, up to $110 for generic or preferred brand, and up to $160 for non-preferred brand medications. Your annual out-of-pocket maximum is $2,000. For more information about how to use this program, call **855-209-1293.**

About Prior Authorization

Prior authorization is required before certain prescription drugs are covered. If your prescription requires prior authorization, you will be notified when you try to fill the prescription at the pharmacy. To request authorization, your physician should call the Catamaran prior authorization line at 855-209-1293. If your prior authorization request is approved, your physician is notified and the coverage is provided. If the request is denied, you and your physician will be notified.

If you have any questions on this prior authorization process, please call 855-209-1293

Short-Term Prescriptions

Short-term medications are generally prescribed to treat illnesses such as colds, flu or strep throat. As shown above, you may receive up to a 30-day supply, and you do not have to file claims.

If you need to fill a short-term prescription, you should have it filled at Walmart, Sam's Club, Target, Kroger, or another Catamaran participating pharmacy. Where you have your prescription filled will determine what you will pay. To locate a Catamaran participating pharmacy in your area, call 855-209-1293 or log on to mywmtotalrewards.com. The plan does not cover any prescription filled at a nonparticipating pharmacy.

		Rx1 – Copay			**Rx2 – Copay/Coinsurance**		
		Generic	Preferred	Non-Preferred	Generic	Preferred	Non-Preferred
30-day supply	Walmart/Sam's	$5	$30	$60	$5	You pay 40% coinsurance $75 max	You pay 60% coinsurance $100 max
	Target/Kroger	$10	$35	$65	$7		
	Other Network Pharmacies	$15	$45	$75	$10		

Copayments

You are required to pay the copayment for each separate prescription or refill. If your prescription does not specify that a brand-name drug must be dispensed and a generic is available, you will receive the generic drug. If a generic drug is available and you purchase a brand-name drug, you must pay the brand copayment amount in addition to the difference in cost between the generic and the brand-name drug.

About Generics

Every prescription has two names:

- The trademark or brand name
- The chemical or generic name

By law, both brand-name and generic drugs must meet the same safety, purity, strength and quality standards. If you fill your prescription through a participating retail pharmacy, you automatically receive the generic equivalent (when available and permitted by law). However, if you or your physician require a brand-name drug, your prescription is filled with the brand-name medication. In this case, you are responsible for paying the price difference between the brand name and generic, in addition to any copay (or coinsurance) amounts that apply.

About the Preferred Drug List (Formulary)

There may be more than one brand-name prescription available to treat your condition. This is why the plan offers a preferred drug list (or formulary). Different copays apply to preferred (formulary) and non-preferred (non-formulary) brand drugs. Medications on the preferred drug list are chosen on the basis of quality, ability to meet patient needs, and cost.

For more information about which prescription drugs are listed on the plan's preferred drug list, call Catamaran at 855-209-1293 or go online at mywmtotalrewards.com.

How to Use Participating Pharmacies

To use a participating pharmacy:

- ➤ Have your physician write your prescription for up to a 30-day supply
- ➤ Take your prescription to the participating pharmacy nearest you
- ➤ Present your Catamaran ID card (you receive your ID card in the mail shortly after you enroll for medical coverage)
- ➤ Verify that your pharmacist has accurate information about you and your covered dependents (including your date of birth and Social Security number)
- ➤ Pay your portion of the prescription cost
- ➤ Sign for and receive your prescription

Long-Term (Maintenance) Prescriptions

Maintenance drugs are for chronic or long-term conditions – such as diabetes, high blood pressure (hypertension), cholesterol and asthma – that usually require taking medicine daily. If you need maintenance drugs, your doctor will write you a long-term prescription.

You can get long-term prescriptions (up to a 90-day supply) at preferred partner pharmacies or through our Home Delivery service. Remember to ask your doctor to write the prescription for a 90-day supply with up to a year of refills, if appropriate.

Prescriptions for maintenance medications can be filled at Walmart, Sam's Club, Target or Kroger. You also have the option of using the Walmart Home Delivery Service, and these drugs will be mailed to you at your home.

For new prescriptions, you may need to get two prescriptions – a long-term prescription for home delivery, and a short-term prescription you can fill at a retail pharmacy while your first home delivery order is being processed.

You can fill a prescription for a maintenance medication at a retail pharmacy up to three times. Then, you must get a 90-day prescription and have it filled at a preferred pharmacy or through Home Delivery for the plan to pay benefits.

		Rx1 – Copay			**Rx2 – Copay/Coinsurance**		
		Generic	Preferred	Non-Preferred	Generic	Preferred	Non-Preferred
90-day supply	Walmart/Sam's	$15	$90	$180	$15	You pay 40% coinsurance $225 max	You pay 60% coinsurance $300 max
	Target/Kroger	$30	$105	$195	$21		
	Home Delivery	$15	$90	$180	$15		
	Other Pharmacies	You will pay 100% of the cost.					

Filling Your Maintenance Prescription at a Participating Pharmacy

Take your prescription to Walmart, Sam's Club, Walmart Neighborhood Market, Kroger and Target pharmacies and get up to a 90-day supply of medication.

- ➤ You can sign up for free reminders, by text or voice message, about your prescription – when it is ready, the cost and when refills are due.
- ➤ You can also sign up for automatic refills.

Filling Your Maintenance Prescription through Home Delivery

You pay the same amount you would for a 90-day supply at a Walmart retail pharmacy, and shipping is free.

Call 1-800-2Refill to refill your prescription, or mail your new prescription, copayment and a new prescription form (available at mywmtotalrewards.com) to:

Walmart Home Delivery
P.O. Box 115112
Carrollton, TX 75011-5112

What the Prescription Drug Program Covers

The prescription drug program covers only drugs that bear the legend: "Caution: Federal law prohibits dispensing without prescription." They also include:

- ➤ Injectable insulin, which may not require a prescription
- ➤ Diabetic supplies, including needles and syringes
- ➤ Growth hormones

What's Not Covered[1]

The program does not cover the following:

- ➤ Prescription drugs that are not medically necessary or that are experimental for indicated conditions (please refer to page 48 of the *Medical* section for a definition of "medically necessary" and "experimental")
- ➤ Prescription drugs dispensed for any illness or injury eligible or covered by any federal, state, or local government, Workers' Compensation Act or occupational disability law
- ➤ Prescription drugs to which you are entitled (with or without charge) under a plan or program of any government or governmental body
- ➤ Treatment or services for injuries that result from the maintenance or use of a motor vehicle, if such injuries are covered under a motor vehicle insurance policy
- ➤ Therapeutic devices or appliances, except as described in this handbook
- ➤ Any prescription for more than a 30-day supply (or a 90-day supply, for a maintenance medication)
- ➤ Charges related to administering drugs or insulin

[1] Excluded drugs listed under "What's Not Covered" may still be available at the plan's negotiated discount rate. If this applies, you will still be responsible for paying 100% of the negotiated cost of the drug, but the cost may be less than if you were to purchase the drug outside of the plan.

- ➤ Any drug or medication, except as described in this handbook
- ➤ Any amounts you are required to pay directly to the dispensing pharmacy for each prescription or refill
- ➤ A prescription, when such drug or medication is used for an unlabeled or unapproved indication, and where such use is not FDA-approved
- ➤ For Home Delivery, any drug or medication that is not a covered maintenance prescription drug
- ➤ Fertility medications
- ➤ Lifestyle drugs (including Viagra and Levitra)
- ➤ Non-sedating antihistamines[2]
- ➤ Proton pump inhibitors (PPIs)[2]

Applying for Benefits

Your prescription drug plan is easy to use. When you go to a participating pharmacy, you do not have to file a claim for the plan to pay benefits. The claim is paid at point of sale.

Filing a Prescription Drug Claim

These procedures apply to claims for prescription drug benefits. The Administrative Committee of the Waste Management Employee Benefits Plan has the authority to decide whether an individual is eligible to participate in the plan. A claim administrator has the authority to decide the level of benefits that are available to an individual. Please refer to page 22 of the ***Participation*** section for more information on eligibility and enrollment claims.

Initial Claim Decision

When a claim is received for a prescription drug benefit, the claim administrator must decide whether (or at what level) the prescription drug benefit is covered under the plan. When the prescription drug benefit is provided or denied, you will receive a notice explaining how the coverage level was calculated or why benefits have been denied.

Appealing a Denial

If you disagree with an adverse determination, you may request a full review by the claim administrator. You must submit this request within 180 days after you receive the adverse determination. A rescission of coverage is treated as an adverse determination and may be appealed. In connection with your appeal, you or your representative can review relevant documents and submit issues and comments in writing. See page 22 for more information concerning relevant documents you can request. If you want to appeal a benefit decision for benefit level claims, send your appeal to the claim administrator listed in the ***Administrative Information*** section of this handbook.

Your appeal will be reviewed and someone other than the person who made the first decision on your claim must make this review. The claim administrator must disclose the identity of any medical or vocational experts who were consulted in connection with your claim. If the benefit decision is based on a medical judgment, the claim administrator must consult with a health care professional who has the appropriate training and experience in the field of medicine involved.

If the claim administrator considers or relies upon any new or additional evidence in making the benefit decision, you will be provided with this evidence, free of charge, as soon as possible and sufficiently in advance of the date the decision is made. If the claim administrator bases the benefit decision on any

[2] Some non-sedating antihistamines and PPIs may be covered at the plan's non-preferred (non-formulary) brand copay for certain indicated medical conditions. Call the claim administrator to determine whether this applies to you.

new or additional rationale, you will be provided with this rationale, free of charge, as soon as possible and sufficiently in advance of the date the decision is made.

After a decision is made concerning your appeal, you will be notified of its findings and decision in writing.

Claims Decisions Notices

The notice given to you concerning the decision on either your initial claim or your appeal will include:

- The specific reason or reasons for the decision
- The specific plan provisions upon which the benefit decision is based
- The denial code and its corresponding meaning, as well as a description of the plan's standard, if any, used in the decision
- Information sufficient to identify the claim involved, including the date of service, health care provider, a notice regarding the availability of the diagnosis and treatment codes and their corresponding meanings, upon request, and claim amount (if applicable)
- A description of any additional material or information that is necessary for you to complete your claim and an explanation of why such material or information is necessary
- If an internal rule, guideline, protocol or similar criterion was relied on in making the decision, either a copy of that document, or a statement that such a document was relied upon and that a copy will be furnished (free of charge) upon request
- If the decision is based on a medical limit (for example, a decision that the proposed service is not medically necessary or that it is experimental), either an explanation of the scientific or clinical judgment for the decision (applying the plan's terms to your medical circumstances), or a statement that such an explanation will be provided free of charge upon request
- A statement disclosing the availability of, and contact information for, any applicable consumer assistance office or ombudsman established to assist individuals with claims and appeals and the external review process
- For an initial claim, a description of the appeal procedures
- For an appeal, a description of the external review procedures
- For an appeal, a statement describing your right to bring a civil action under section 502(a) of ERISA following the denial of your appeal

External Review Procedures

If you disagree with the decision concerning your appeal, you may be eligible to request an external review of your claim. To be eligible for an external review, you must:

- Have been covered under the plan when the service was requested/provided
- Exhausted the plan's claims and appeals procedures, listed above
- Have a claim that relates to a question of medical judgment or a rescission of coverage, and
- Have provided all information and documentation required to process external review

If you are eligible to file a request for external review, you must send your request to the claim administrator listed in the Administrative Information section of this handbook within four months of receiving the adverse decision concerning your appeal. The external review will be assigned to an independent review organization (IRO). If you believe an expedited external review is necessary to avoid jeopardizing your life or health, you must file a request for an expedited review with the claim administrator.

Exhaustion of Administrative Remedies

You must exhaust all administrative remedies in this section (with the exception of the external review procedures) before you may bring a civil action following a denial of benefits. In any event, your civil action must be brought within two years from the date the claim was first filed.

Dental

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Dental care is an integral part of your overall wellness. That is why dental coverage is offered as part of your Waste Management Health and Welfare Benefits Plan.

The dental plan pays benefits for a wide range of dental services – from preventive and routine care to the treatment of serious dental problems. As you read about your coverage, keep in mind the following:

If You Have Questions

If you have questions about your dental benefits, go to mywmtotalrewards.com.

- You may enroll in dental coverage regardless of which medical option you choose
- You may select coverage for you and your eligible dependents. You also may waive coverage. If you elect to waive coverage, you are not eligible for benefits for any dental work, whether preventive, routine, serious dental care or any other dental services described in this handbook
- You may enroll in one of two options: dental with orthodontia, or dental without orthodontia
- Under either option, benefits are paid for preventive, basic and major services. If you enroll in the dental with orthodontia option, benefits also are paid for orthodontic services
- Under either option, the level of benefits you receive depends on which dentist you choose. You can receive services from a dentist of your choice. However, if you go to a Delta Dental network participating dentist (PPO or Premier), you may pay less for your dental treatment. This is because Delta Dental participating dentists accept Delta Dental's approved fee as payment-in-full for eligible charges. For Delta Dental PPO dentists, the approved fee is the negotiated fee. For Delta Dental Premier dentists, the approved fee is the Maximum Plan Allowance or MPA (formerly known as the usual, customary and reasonable fee or UCR fee). Participating dentists in the PPO or Premier network will also file the claim for benefits
- You should always try to use the PPO network of dentists because the benefits are better when a PPO dentist is used, saving you money. If you do not wish to use a PPO dentist, Premier dentists also offer cost savings
- If you choose a dentist who does not participate in a Delta Dental network, your dentist is not obligated to accept the Delta-approved fee for the service. This means you pay the difference between the Delta-approved fee and the fee your non-participating dentist charges

A Snapshot of Your Dental Coverage

The following chart is a snapshot of the dental coverage described in this handbook. The Plan pays benefits based on the Delta-approved fee. See ***Eligible Charges*** on page 69 for a description of MPA.

Benefit	PPO	Premier	Out-of-Network
Annual Deductible			
Individual	$50	$50	$75
Family	$150	$150	$225
Benefit	**Plan Pays**	**Plan Pays**	**Plan Pays**
Coinsurance			
Preventive/Diagnostic	100% no deductible	100% after deductible	90% after deductible
Basic	80% after deductible	80% after deductible	70% after deductible
Major	50% after deductible	50% after deductible	40% after deductible
Orthodontia*	50% after deductible	50% after deductible	50% after deductible
Annual Plan Maximum	$2,500	$2,500	$2,500

*Orthodontic supplies and related professional treatment are only covered under the "dental with orthodontia" option. The orthodontia lifetime maximum is $2,500 per covered individual.

How Your Dental Coverage Works

This section provides a brief overview of how your dental coverage works.

Coverage Choices

You have the following dental choices available to you:

- Dental with orthodontia
- Dental without orthodontia

If you choose the “dental without orthodontia” option, orthodontia treatment is not covered.

About Your Coverage

If you enroll in one of the options, the plan pays a percentage of the Delta-approved fee once you satisfy the annual deductible (where applicable). For treatment from a PPO dentist, the Delta-approved fee is the negotiated fee. For treatment from a Premier or out-of-network dentist, the Delta-approved fee is the MPA. The percentage the plan pays depends on the type of service you receive.You are responsible for the remaining expenses. See the snapshot chart for the deductibles and coinsurance that apply for each type of service.

The plan pays benefits for eligible charges whether or not you visit a participating dentist. However, you can maximize your benefit and have lower out-of-pocket expenses if you use a participating dentist. See page 68 for details regarding participating and non-participating dentists.

Choosing Whom to Cover

You may choose dental coverage for:

- You
- You + spouse
- You + child(ren)
- You + family (you, your spouse and children)

Please refer to the ***Participation*** section of this handbook for details on who is eligible.

How the Plan Pays Benefits

Depending on the type of service you receive, a deductible, coinsurance, as well as annual and lifetime maximums may apply. A brief description of each follows.

Deductibles

The deductible is the amount you pay each year before the plan pays benefits. Generally, a deductible is required for all dental services. If you visit a PPO dentist, however, you do not have to satisfy a deductible requirement before the plan pays benefits for eligible preventive or diagnostic services. See the snapshot chart on page 66 for the deductible (if any) that applies.

The individual deductible applies separately to each covered individual, and the family deductible applies to all covered persons in the same family. Once you meet the family deductible, your remaining covered family members do not have to meet their individual deductible amounts for the rest of that year.

However, one covered family member cannot apply more than his or her individual deductible amount toward the family deductible, and payments made for dental benefits not subject to a deductible cannot be applied toward the maximum deductible amount.

Coinsurance

You are responsible for a percentage of the Delta-approved fee after you meet your annual deductible. The percentage you pay is called your coinsurance, and depends on the type of service you receive. See the snapshot chart on page 66 for the percentage your plan pays for each service. The remaining percentage is your coinsurance.

Please note: If you receive care from a non-participating dentist, the percentage the plan pays applies only to eligible expenses that do not exceed the MPA. You are responsible for the cost of any service that the plan does not cover, and any amount that exceeds the MPA. See ***Eligible Charges*** on page 69 for a description of the MPA.

Maximum Benefits

All options pay benefits of up to $2,500 for preventive, basic and major services. This is an individual maximum that applies separately to each covered family member per calendar year.

Orthodontia

If you choose the “dental with orthodontia” option, there is a separate maximum of $2,500 per lifetime for the orthodontia coverage of each covered person. At the time orthodontia treatment begins, the orthodontist generally files a claim for the entire course of orthodontia treatment. Delta Dental then determines the benefits to be paid over the course of treatment and sets up a payment schedule consisting of an initial payment followed by monthly payments for treatment. Delta Dental will continue to make the monthly payments during the orthodontia treatment until the $2,500 lifetime maximum benefit for orthodontia is reached or the patient is no longer enrolled in the “dental with orthodontia option.” Any monthly amounts for periods when you are not enrolled in the “dental with orthodontia” option are not covered. This means that if you enroll in “dental with orthodontia” in a year and begin orthodontia treatment but enroll in “dental without orthodontia” in the next year, the monthly payments for the orthodontia treatment will stop.

Participating and Non-Participating Dentists

The plan pays benefits for eligible charges whether you go to a participating or non-participating provider.

Participating Dentists

If you go to a dentist who participates in a Delta Dental network, you may receive a greater level of benefits under the plan and pay less for your dental expenses. This is because Delta Dental network participating dentists agree to accept Delta Dental’s approved fee as payment-in-full for eligible services. Additionally, your plan pays benefits directly to your dentist, and after you pay any applicable deductible and coinsurance amounts, your dentist does not bill you for any difference between the approved fee and his or her submitted fee.

A Delta Dental network participating dentist will also file the claim for you.

To receive the most up-to-date list of participating dentists in your area, contact Delta Dental at 800-398-7203 or log on to mywmtotalrewards.com and choose the links to find a provider. Only dentists participating in either the Delta Dental PPO or Delta Dental Premier network display in the results. If the dentist participates in the PPO network, this designation is included in the provider profile. If no network designation is shown, the dentist is in the Premier network only. You may also log on to deltadentalil.com to locate a PPO or Premier participating dentist.

Non-Participating Dentists

If you go to a dentist who does not participate in a Delta Dental network, you may receive a lower level of benefit and pay more for your treatment. This is the case because non-participating dentists are not obligated to accept Delta Dental's approved fee as payment in full. As a result, you are responsible for any difference between what the plan pays and what your dentist charges for the service. In this case, the plan may pay benefits directly to you after you file the necessary claim.

Eligible Charges

When receiving out-of-network care, the plan pays benefits for eligible charges based on the Maximum Plan Allowance (MPA). The MPA:

- Is the fee most frequently charged by the majority of dentists for a similar service or procedure
- Falls within the prevailing range of what other dentists with similar training and experience charge for the same service in a given geographic area

Alternative Procedures

Sometimes there is more than one way to treat a dental problem, e.g., repairing a tooth with silver filling instead of gold. Eligible charges under the plan are the least costly procedure that treats the condition and meets acceptable medical standards.

What the Plan Covers

The plan pays benefits, up to the negotiated fee or the MPA, for the following medically necessary dental services and supplies. See the snapshot chart on page 66 to see how the plan options pay benefits for each particular covered service, and any benefit limits that may apply.

Preventive/Diagnostic Services

The plan pays benefits for the following preventive and diagnostic services. Remember, if you go to a Delta Dental PPO dentist, you do not have to satisfy a deductible requirement before the plan pays benefits for these services.

- Initial examination or comprehensive oral examination from a new dentist
- Periodic detailed oral evaluations, up to two per calendar year
- Dental consultations
- X-rays, including:
  - Bitewing X-rays, up to two per calendar year
  - Complete full-mouth X-rays (including bitewing X-rays and panoramic X-rays in conjunction with any other X-rays), up to one per 36-month interval
  - Periapical X-rays (as required)
- Dental prophylaxis, up to two per calendar year
- Topical fluoride treatments for dependent children under age 19, up to one per calendar year
- Space maintainers for dependent children under age 14
- Sealants applied once per tooth to permanent first and second molars that are free of cavities and restorations for dependent children under age 16
- Emergency examinations and treatment for an accidental injury or when necessary to relieve pain (when not related to a final procedure)

Basic Services

The plan pays benefits for the following basic services once you meet the annual deductible requirement, up to the annual maximum per individual:

- Fillings (amalgam and resin restorations), up to one per tooth every 12-month interval
- Simple extractions and surgical procedures needed to treat disease of the gums and bones supporting the teeth, up to once per quadrant every 24-month interval
- Scaling (non-surgical periodontal therapy) to treat diseases of the gums, up to once per quadrant every 24-month interval
- Periodontal maintenance procedures following active periodontal therapy (maximum of twice per calendar year) including:
  - Examination
  - Prophylaxis
  - All related procedures
- Endodontics, including pulpal and root canal therapy
- Oral surgery, including extractions and other pre- and post-operative care when provided in a dentist's office
- General anesthesia when related to the oral surgical procedure and provided by a dentist
- Occlusal guards

Major Services

The plan pays benefits for major dental services designed to treat more serious dental problems. Once you meet the annual deductible requirement, the plan pays benefits for the following services, up to the annual maximum per individual:

- Initial insertion of crowns, inlays, onlays and ceramic restorations (permanent teeth only)
- Necessary replacement of crowns, inlays, onlays, dentures and bridges (but not more than once every five years)
- Cast restorations, fixed partial dentures, removable partial dentures, complete dentures, and denture service
- The reline or rebase of an existing appliance, up to one each 36-month interval
- Bridges
- Repair or recementing of crowns, bridges and dentures
- Initial insertion of implants. The plan does not pay for replacement of your implants within 60 months of the original covered implant.

Orthodontia Services

If you enroll in the "dental with orthodontia" option, the plan also pays benefits for orthodontia supplies and professional treatment needed to properly align teeth. For information concerning limits on these services or how these services are paid, see the ***Maximum Benefits*** section on page 68.

Dental Expenses Not Covered

The plan does not pay benefits for the following:

- Consultations by a dentist performing treatment
- Repairs of space maintainers
- Re-cementation of a space maintainer by the same office within six months of its initial placement
- Restorations if there is no evidence of decay or missing tooth structure, or for the following:
  - Cosmetics
  - Abrasion
  - Attrition
  - Erosion
  - Restoration or alteration of vertical dimension
  - Congenital or developmental malformations of teeth
  - The anticipation of future fractures
- Restorations, when crowns are allowed for the same tooth or teeth
- Surgical periodontal therapy, if X-rays show no evidence of bone loss
- Grafts or gingivectomies performed in conjunction with osseous surgery
- Guided tissue regeneration
- Crown lengthening or gingivoplasty, if not performed at least four weeks before the preparation of the crown
- Non-surgical periodontal therapy, if X-rays show no evidence of bone loss
- Root canal filled with material not approved for endodontic therapy by the American Dental Association
- Retreatment of the same tooth by the same office with the same endodontic procedure
- Endodontic procedures performed in conjunction with complete, removable prosthodontic appliances
- Pulpal therapy on non-vital teeth
- Alveolectomy or alveoloplasty performed in conjunction with surgical or multiple simple extractions
- Bone replacement grafts performed in conjunction with extractions or implants
- Replacement of any existing cast restoration or prosthodontic appliance (cast restorations, fixed partial dentures, removable partial dentures, complete dentures) with any prosthodontic appliance within five years following initial placement of the existing appliance
- Cast restorations, if there is no radiographic evidence of decay or missing tooth structure, or for the following purposes:
  - Cosmetics
  - Abrasion
  - Attrition
  - Erosion
  - Restoration or alteration of vertical dimension
  - Congenital or developmental malformations of teeth
  - The anticipation of future fractures
- Crown build-up, if there is sufficient vertical height on a tooth to support a cast restoration
- Recementation by the same office within six months of initial placement
- Gold foil restorations
- Fixed or removal partial dentures, if a fixed partial denture and a removable partial denture are requested or placed in the same arch
- The reline or rebase of an existing appliance within six months after the initial placement
- Fixed partial denture for a child under age 16
- Tissue conditioning
- False teeth (a pontic), if the space between teeth is less than 50% of the size of the missing tooth
- Precious metal dentures

- Services, supplies or treatments that are:
  - Compensable under workers' compensation or employers' liability laws
  - Provided or paid for by any governmental agency or any governmental program or law (this includes benefits provided under the U.S. Social Security Act)
  - Performed to correct developmental malformation including cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis and anodontia
  - Performed for purely cosmetic purposes, including veneers, bonding, porcelain restorations and microabrasion
- Charges for services completed before the coverage effective date
- Services of anesthetists or anesthesiologists
- Temporary procedures
- Any procedure, if less than 40% of the tooth is supported by bone
- Services performed on nonfunctional teeth (the second or third molar without an opposing tooth)
- Services performed on deciduous teeth near exfoliation
- Drugs or the administration of drugs, except for general anesthesia in conjunction with oral surgery
- Experimental procedures
- Services related to any disturbance of the temporomandibular joint (jaw joint)
- Any procedures, techniques or materials related to implantology or edentulous ridge enhancement, including prosthodontic appliances connected to implants, except that when an implant and related prosthodontic appliance are placed, a benefit may be allowed at the level of a pontic or other covered prosthodontic service, subject to professional review. If such an allowance is made, replacement within 60 months thereafter is not a covered benefit.
- Services performed as a component of another procedure
- Charges associated with failing to complete claim forms or submitting other required information
- Infection control procedures and fees associated with Occupational Safety and Health Administration requirements
- Replacement of lost or stolen appliances
- Plaque control programs
- Oral hygiene instruction
- Nutritional counseling services

Applying for Benefits

Your dental plan is easy to use. If you go to a PPO or Premier participating dentist, you do not have to file a claim for the plan to pay benefits. If you go to a nonparticipating dentist, you may be required to file a claim to apply for benefits.

How to File a Claim for Non-Participating Dentists

When you receive routine dental care, simply fill out your portion of the claim form. Be sure to include your (the employee's) full name and address, ID number (found on your ID card), the patient's name and date of birth, and the group name and number (Waste Management, Group 5649). Have your dentist complete his or her part, and mail the form to:

Delta Dental of Illinois
P.O. Box 5402
Lisle, IL 60532

Dental claim forms can be found on Delta Dental's Website (deltadentalil.com). You can also link to Delta Dental's website by going to mywmtotalrewards.com. If you have questions about your claim, call Delta Dental at 800-398-7203.

Please make every reasonable effort to file claims within 90 days after you receive dental care.

Predetermination of Benefits

The plan handles serious dental procedures differently from routine dental care. If you or a covered dependent plan to undergo a serious procedure and you expect a large dental bill (over $300), you should obtain an estimate of the cost before you (or your dependent) receive the dental work.

You are not obligated to receive a predetermination of benefits for services less than $300, emergency examinations or treatments, or oral surgical procedures that result from an injury. However, if you want to find out what the plan will pay before you receive services, it is a good idea to request a predetermination of benefits beforehand.

How to Get a Predetermination of Benefits

To get a predetermination of benefits for you or your dependents:

- Before treatment begins, have your dentist submit a request for a predetermination of benefits to Delta Dental
- The request should include the:
  - Dental needs or written treatment
  - Description of the procedures and services the treating dentist plans to perform
  - Actual fees to be charged for each service or procedure
  - Supporting documentation – includes full-mouth X-rays for non-surgical periodontics, surgical periodontics and complete dentures. It includes full-arch X-rays for osseous fractures and fixed and removable partial dentures. It includes periapical X-rays for surgical extractions and cast restorations. It includes narrative for consultations, palliative treatment, emergency exams and general anesthesia. It also includes a histopathology/hospital report for biopsies and surgical excision of tissue
- Delta Dental reviews the request and returns it, showing an estimate of what portion of the total bill the plan will pay. Note that a pre-treatment estimate does not consider other coverage you may have. Delta Dental coordinates benefits after treatment is completed and a claim is submitted for payment.

Predetermination of benefits protects you. By knowing the estimated amount the plan will pay before treatment begins, you should not be faced with surprise expenses. Whether or not you get a predetermination of benefits, the plan pays benefits for the Delta Dental approved fees for services and supplies that Delta Dental determines are medically necessary. Also, if you receive services more than 90 days after the plan issues its predetermination of benefits, you must submit your claim with the supporting documentation outlined above.

Claim Filing Deadline

You have up to one year from the date of services or supplies are provided to file a claim for benefits. Claims filed more than one year after the date of services or supplies are provided will not be eligible for benefits.

Filing a Dental Claim

These procedures apply to dental benefit claims. The Administrative Committee of the Waste Management Employee Benefit Plan has the authority to decide whether an individual is eligible to participate in the plan. A claim administrator has the authority to decide the level of benefits that are available to an individual. Please refer to page 22 of the ***Participation*** section for more information on eligibility and enrollment claims.

Initial Claim Decision

When a claim is received for a dental benefit, the claim administrator must decide whether (or at what level) the dental benefit is covered under the plan. When the dental benefit is provided or denied, you will receive a notice explaining how the coverage level was calculated or why benefits have been denied. How fast this notice must be given to you depends on whether the claim is an urgent care claim, a pre-service claim or a post-service claim. The deadline for this notice is no later than:

- For an urgent care claim, 72 hours after the claim is received
- For a pre-service claim, 15 days after the claim is received
- For a post-service claim, 30 days after the claim is received

The following rules apply if your claim is an urgent care claim or a pre-service claim:

- You will be notified of the decision whether or not it is adverse
- You can be notified of an initial decision orally, if a written or electronic notice is provided no more than three days after the oral notice

Failure to Follow Urgent Care or Pre-Service Claims Procedures

If you fail to follow the procedures for filing an urgent care claim or a pre-service claim, you will be notified of the failure and the proper procedure to be followed. This notice must be provided to you no later than 24 hours after the failure for urgent care claims or five days after the failure for pre-service claims. This notice may be oral unless you (or your representative) request a written notice. This notice is triggered when:

- You (or your representative) make a communication that is received by a person or organization unit customarily responsible for handling benefit matters and
- The communication names a specific participant or covered dependent, a specific medical condition and a specific treatment, service or product for which approval is requested

Notice of Incomplete Urgent Care Claim

If you (or your representative) properly submit an urgent care claim that is missing necessary information, you will receive a notice. This notice will tell you the specific information needed to complete the claim. The notice will be given to you no later than 24 hours after receiving the claim. You must be given a reasonable time to provide the information but not less than 48 hours. You will be notified of the decision concerning your urgent care claim as soon as possible but no later than 48 hours after the earlier of:

- When the plan receives the requested information or
- The end of the period you were given to provide the information

Concurrent Care Claim

At times, the claim administrator may approve a course of treatment that is provided over time or for a specific number of treatments. If the claim administrator later terminates or reduces approval for a course of treatment, it will notify you of this decision so you will have sufficient time to appeal that decision before the course of treatment is reduced or terminated.

If you need to extend a course of treatment and the original request for the treatment was an urgent care claim, you should contact the claim administrator at least 24 hours before the approved course of treatment will expire. If you do so, the claim administrator will provide you with a notice of its decision concerning the requested extension within 24 hours of your request. If you request an extension later, you will receive notice of the claim administrator’s decision based on whether that request is an urgent care or pre-service claim.

Appealing a Denial

If you disagree with a denial, you may request a full review by the claim administrator. You must submit this request within 180 days after you receive the denial notice. In connection with your appeal, you or your representative can review relevant documents and submit issues and comments in writing. See page 22 for a description of the relevant documents you can request. If you want to appeal a decision for benefit level claims, send your appeal the claim administrator listed in the ***Administrative Information*** section of this handbook.

Your appeal will be reviewed and someone other than the person who made the first decision on your claim must make this review. The claim administrator must disclose the identity of any medical or vocational experts who were consulted in connection with your claim. If the benefit decision is based on a medical judgment, the claim administrator must consult with a health care professional who has the appropriate training and experience in the field of medicine involved.

After a decision is made concerning your appeal, you will be notified of its findings and decision in writing. This notice will be provided no later than:

- For an urgent care claim, 72 hours after receiving the appeal
- For a pre-service claim, 30 days after receiving the appeal
- For a post-service claim, 60 days after receiving the appeal

Claims Decisions Notices

The notice given to you concerning the decision on either your initial claim or your appeal will include:

- The specific reason or reasons for the decision
- The specific plan provisions upon which the benefit decision is based
- A description of any additional material or information that is necessary for you to complete your claim and an explanation of why such material or information is necessary
- If an internal rule, guideline, protocol or similar criterion was relied on in making the decision, either a copy of that document, or a statement that such a document was relied upon and that a copy will be furnished (free of charge) upon request
- If the decision is based on a medical limit (for example, a decision that the proposed service is not medically necessary or that it is experimental), either an explanation of the scientific or clinical judgment for the decision (applying the plan's terms to your medical circumstances), or a statement that such an explanation will be provided free of charge upon request
- For an initial claim, a description of the appeal procedures

Voluntary Appeal Procedures

You have an additional option if your appeal of a dental benefit claim is denied by the claim administrator. You may use (but are not required to use) this voluntary appeal process.

If you have received a final decision from the claim administrator after following the claims appeal procedures described above, you may ask that the Administrative Committee review that decision under these voluntary appeal procedures. You are not required to use these voluntary appeal procedures. If you choose not to use these voluntary appeal procedures and subsequently bring suit, failure to use these voluntary appeal procedures will not be raised or used against you. Your decision to use these voluntary appeal procedures will have no effect on your rights to any other benefits under the plan. If you choose to use the voluntary appeal procedures and you are not satisfied with the final decision, you have the right to bring a civil action under ERISA Section 502(a).

To use this voluntary appeals process, you (or your representative) must submit a written request to the Administrative Committee (see page 168 for contact information) within 30 days after you receive a final decision from the claim administrator. Your request should include:

- An explanation of why you believe that the claim administrator's final decision is wrong
- A copy of the final decision of the claim administrator
- Any other documents you believe are relevant or helpful to your appeal

To decide your request for a voluntary appeal, the Administrative Committee will need a copy of the claim administrator's records of your appeal. As part of the voluntary appeal process, you may be required to sign a permission form allowing the claim administrator to release these records to the Administrative Committee. If you do not give any required permission, you cannot use this voluntary appeal process.

Within 120 days after the Administrative Committee receives your appeal and permission, the Administrative Committee will provide you with a written decision. If the Administrative Committee grants your appeal, you will be notified and told what portion of the claim administrator's decision is changed. If the Administrative Committee's decision affirms the claim administrator's decision, in whole or in part, you may bring a civil action under ERISA Section 502(a) or take whatever other action you choose.

If you file a voluntary appeal, there is no charge to you. You are, however, responsible for your own costs of mailing and copying your appeal request documents, and the cost of any personal representative you may use.

Vision

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Vision coverage, if you elect it, provides coverage for you and your family members. You may enroll in vision coverage regardless of which medical option you choose. Routine eye exams are also provided under VSP. However, remember if you elect medical coverage, routine eye exams also are covered under that program.

A Snapshot of Your Vision Coverage

Below is a snapshot of the vision coverage described in this handbook.

	Plan Pays	
Covered Services	**In-network**	**Out-of-network**
Eye Exam 1/person/year	100%	Up to $50
Lenses*		
Single	100% after $25 copayment	Up to $50
Lined Bifocal	100% after $25 copayment	Up to $75
Lined Trifocal	100% after $25 copayment	Up to $100
Lenticular	100% after $25 copayment	Up to $125
Covered Frames**	Up to $140 after $25 copayment	Up to $70
Contact Lenses	Up to $140 allowance	Up to $120 allowance
Laser Vision Correction***	$250 per eye	Not Applicable

*One pair per calendar year per person.
**One pair per two calendar years per person
***Through VSP's Laser VisionCare^{sm} Preferred Program, laser vision correction surgery (LASIK, Custom LASIK or PRK) is covered up to a maximum of $250 per eye. Your VSP doctor will coordinate referrals for qualified candidates to **participating Laser Surgery Centers**. Contact your VSP doctor for a referral.

Please note, a covered individual cannot receive glasses and contacts in the same year.

How Your Vision Coverage Works

This section provides a brief overview of how your vision coverage works.

How the Plan Pays Benefits

You may obtain materials from a VSP doctor or an out-of-network provider. If you obtain materials from a VSP doctor, the plan pays 100% of the cost on lenses (single, lined bifocal, lined trifocal and lenticular) and up to $140 retail allowance on frames, after you pay the required copayments.

If you obtain materials from an out-of-network provider, you pay for the materials in full at the time of service. You must then submit a statement of services to VSP for reimbursement. See the chart for more details.

Maximum Benefits

If you receive materials from either a VSP provider or an out-of-network provider, the plan allows for a routine eye exam every calendar year, lenses every calendar year (prescription lenses or contact lenses) and frames every other calendar year.

VSP Doctor and Out-of-Network Provider

The plan pays benefits for eligible charges whether you go to a VSP doctor or an out-of-network provider.

VSP Doctors

VSP Doctors offer the convenience of providing complete vision care (exam, prescription eyeglasses and contacts) and the benefit of nationwide access to low cost pricing on all lens options. Savings average 30%.

How to use your vision benefits:

- You can locate a VSP doctor near you using these tools:
  - Call VSP at 800-877-7195
  - Visit the VSP website at vsp.com
  - Log on to mywmtotalrewards.com
- Call the VSP doctor to make an appointment
- Identify yourself as a VSP participant
- Provide your first name, last name, date of birth and last four digits of your social security number
- The VSP doctor contacts VSP to verify your eligibility and obtain an authorization for available services. If you are not eligible for services, the office will inform you at this time.
- You may purchase your materials, prescription eyeglasses, or contacts from the VSP doctor. Every office has a selection of frames with varied prices.

As long as you receive services from a VSP doctor, there is no claim to file. The doctor submits a claim to VSP directly. You pay the difference between the plan's allowed amount and the actual charges.

If you go to a VSP doctor, be sure to mention that you are a VSP member. If you do not, the provider may treat you as a "private patient." As a result, you may not receive the plan's discounts.

Out-of-Network Providers

If you prefer, you can go to an out-of-network provider that is not part of the VSP network. If you do, you pay the provider's regular charges in full. You are responsible for submitting your itemized statement to VSP for reimbursement. Make copies of this information for your records. Your submitted items will not be returned.

What the Plan Covers

The plan covers the following services:

- Exam – a routine eye examination
- Lenses – prescription lenses you need for visual welfare
- Frames – a frame of your choice is covered in full up to $140 retail allowance. If the frame you choose is more than the retail frame allowance you are responsible for the difference. However, if you use a VSP doctor, you may also be eligible for a discount
- Contact lenses (medically necessary and elective) – You can receive a discount for the professional fees associated with receiving contact lenses, as well as an allowance for the contacts themselves

- Laser surgery (commonly known as LASIK) – The plan will pay up to $250 per eye for PRK, LASIK, or Custom LASIK surgery performed by a participating provider (contracted laser surgery center). You must first start with your VSP doctor for a complimentary screening to determine if you are a good candidate for vision correction surgery. Your VSP doctor will coordinate referrals for qualified candidates to participating Laser Surgery Centers

Vision Expenses Not Covered

The plan does not pay benefits for the following:

- Fees for securing materials, such as eyeglass lenses and frames
- Orthoptics or vision training and any associated supplementary testing
- Medical or surgical treatment (excluding laser surgery) of the eyes
- Any eye examination required by the employer as a condition of employment
- Any amounts that exceed the scheduled amount

Applying for Benefits

Your vision plan is easy to use. If you receive care from a VSP provider, you do not have to file a claim for benefits. If you receive care from a nonparticipating provider, you will be required to file a claim for benefits.

How to file an out-of-network claim:

- Send your itemized receipt, be sure to include:
  - The patient's name
  - Your relationship to the patient (i.e., self, spouse, child)
  - Your name, mailing address, date of birth and last 4 digits of your social security number
  - Your employer's name
- Mail this information to:
  VSP
  Attn: Out-of-Network Claims
  P.O. Box 997100
  Sacramento, CA 95899-7100

Deadline for Filing an Out-of-Network Claim

You have up to six months from the date services or materials are provided to file a claim for reimbursement. Claims filed more than six months after the date of services or materials are provided will not be eligible for benefits.

Filing a Vision Claim

These procedures apply to vision benefit claims. The Administrative Committee of the Waste Management Employee Benefits Plan has the authority to decide whether an individual is eligible to participate in the plan. An insurance company has the authority to decide the level of benefits that are available to an individual. Please refer to page 22 of the ***Participation*** section for more information on eligibility and enrollment claims.

Initial Claim Decision

When a claim is received for a vision benefit, the insurance company must decide whether (or at what level) the vision benefit is covered under the plan. When the vision benefit is provided or denied, you will receive a notice explaining how the coverage level was calculated or why benefits have been denied.

Appealing a Denial

If you disagree with a denial, you may request a full review by the insurance company. You must submit this request within 180 days after you receive the denial notice. In connection with your appeal, you or your representative can review relevant documents and submit issues and comments in writing. See page 22 for a description of the relevant documents you can request. If you want to appeal a decision for benefit level claims, send your appeal the insurance company listed in the ***Administrative Information*** section of this handbook.

Your appeal will be reviewed and someone other than the person who made the first decision on your claim must make this review. The insurance company must disclose the identity of any medical or vocational experts who were consulted in connection with your claim. If the benefit decision is based on a medical judgment, the insurance company must consult with a health care professional who has the appropriate training and experience in the field of medicine involved.

After a decision is made concerning your appeal, you will be notified of its findings and decision in writing.

Claims Decisions Notices

The notice given to you concerning the decision on either your initial claim or your appeal will include:

- The specific reason or reasons for the decision
- The specific plan provisions upon which the benefit decision is based
- A description of any additional material or information that is necessary for you to complete your claim and an explanation of why such material or information is necessary
- If an internal rule, guideline, protocol or similar criterion was relied on in making the decision, either a copy of that document, or a statement that such a document was relied upon and that a copy will be furnished (free of charge) upon request
- If the decision is based on a medical limit (for example, a decision that the proposed service is not medically necessary or that it is experimental), either an explanation of the scientific or clinical judgment for the decision (applying the plan's terms to your medical circumstances), or a statement that such an explanation will be provided free of charge upon request
- For an initial claim, a description of the appeal procedures

Employee and Family Assistance Program

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The Employee and Family Assistance Program (EFAP) is available to help you and your eligible dependents receive confidential, professional, short-term counseling and referral services. See the ***Your Eligible Dependents*** section for information concerning who is an eligible dependent. As you read about the EFAP, consider the following:

- ➤ The Company pays the cost of the EFAP. You do not pay anything for this program
- ➤ You do not have to enroll for medical coverage to use the EFAP
- ➤ Access to EFAP services is available to you and your family members 24 hours a day, seven days a week
- ➤ Counseling is confidential, except when disclosure is required by law

If You Have Questions

Contact Cigna Behavioral Health at 800-862-3558. EFAP counselors are available 24 hours a day, seven days a week.

A Snapshot of the EFAP's Services

The EFAP offers assistance with a variety of personal concerns. It can help assess a problem, provide professional counseling services, provide confidential care, educate, provide follow-up care, and refer you to additional resources if needed.

This can include many things, from relationship issues to drug and alcohol abuse to a simple referral for a day care provider. The following chart is a snapshot of the things the EFAP can help with and a brief description of each.

Concerns	The EFAP Can Assist With
Family	Child care referrals Parenting problems Elder day care Adoption support Marital difficulties Serious illness or death of a family member Aging parents
Marital/Relationship	Divorce Communication facilitation Conflict resolution Domestic violence issues Dual career issues
Legal	Accessing legal advice over the telephone Referrals to local attorneys who provide services for discounted fees
Identity Theft Financial	Consultation Credit management Free in-depth needs analysis Debt counseling
Work-Related	Interpersonal problems Balancing work and family Job dissatisfaction Conflicts with authority Time management Relocation issues
Alcohol Abuse	Abuse that affects work performance Abuse that affects relationships Abuse that affects family life Abuse that results in mood swings

Concerns	The EFAP Can Assist With
Drug Abuse	Prescription drug abuse Multi-drug use problems Illegal drug abuse Drug use while at work Drug problems within families
Emotional	Stress Anxiety Depression Mood swings Lack of emotional self-control Unresolved anger

How the EFAP Works

You and your family have access to confidential, professional assistance 24 hours a day, seven days a week. Call the EFAP anytime at 800-862-3558.

Why This Program?

Personal concerns can affect your physical, emotional and spiritual well-being. These concerns also can affect your marriage, your performance on the job and your financial security.

WM put the EFAP in place because:

- ➤ Employees are key to WM's success
- ➤ The organization is dependent on your best performance
- ➤ Your personal health, as well as your family's well-being is important to WM

When You Call the EFAP

When you call the EFAP, a professionally trained clinician is available to speak with you. Many problems can be resolved in a brief period of time through the EFAP. However, if the problem requires more in-depth counseling, you and/or your family member may be referred to another professional for additional assistance. Any costs associated with a referral to another professional are your responsibility. Often, the medical plan will cover some or all of the costs.

Workplace Support Services (WSS)

If you are a WM employee in a supervisory or management role, the EFAP also provides a range of consulting services to help you support your staff when a catastrophic or behavior-related workplace crisis occurs. By calling the EFAP and asking to speak with an Employee Assistance Consultant, managers, supervisors, and Human Resources representatives have access to expert advice on a wide range of behavior-related workplace challenges.

The Employee Assistance Consultant can help you deal with such concerns as job performance, positive drug and alcohol test results, threats of violence, and critical/serious incidents that may take place at your work site. You can reach professional, clinical staff 24 hours a day via the same toll-free phone number: 800-862-3558.

Covered Services

WM covers the cost of services provided by the EFAP. The program provides for up to six EFAP professional counseling visits per person, per problem, per year. For an authorization and referral to an EFAP provider, call 800-862-3558. Extremely complex situations may be referred to other resources. If you or a family member needs additional assistance/resources, your medical coverage may cover additional services. See pages 40-50 of the ***Medical*** section of this handbook for details.

Filing an EFAP Claim

These procedures apply to claims made for EFAP benefits. The Administrative Committee of the Waste Management Employee Benefits Plan has the authority to decide whether an individual is eligible to participate in the plan. A claim administrator has the authority to decide the level of benefits that are available to an individual. Please refer to page 22 of the ***Participation*** section for more information on eligibility and enrollment claims.

Initial Claim Decision

When a claim is received for an EFAP benefit, the claim administrator must decide whether (or at what level) the EFAP benefit is covered under the plan. When the EFAP benefit is provided or denied, you will receive a notice explaining how the coverage level was calculated or why benefits have been denied. How fast this notice must be given to you depends on whether the claim is an urgent care claim, a pre-service claim or a post-service claim. The deadline for this notice is no later than:

- For an urgent care claim, 72 hours after the claim is received
- For a pre-service claim, 15 days after the claim is received
- For a post-service claim, 30 days after the claim is received

The following rules apply if your claim is an urgent care claim or a pre-service claim:

- You will be notified of the decision whether or not it is adverse
- You can be notified of an initial decision orally, if a written or electronic notice is provided no more than three days after the oral notice

Failure to Follow Urgent Care or Pre-Service Claims Procedures

If you fail to follow the procedures for filing an urgent care claim or a pre-service claim, you will be notified of the failure and the proper procedure to be followed. This notice must be provided to you no later than 24 hours after the failure for urgent care claims or five days after the failure for pre-service claims. This notice may be oral unless you (or your representative) request a written notice. This notice is triggered when:

- You (or your representative) make a communication that is received by a person or organization unit customarily responsible for handling benefit matters and
- The communication names a specific participant or covered dependent, a specific medical condition and a specific treatment, service or product for which approval is requested

Notice of Incomplete Urgent Care Claim

If you (or your representative) properly submit an urgent care claim that is missing necessary information, you will receive a notice. This notice will tell you the specific information needed to complete the claim. The notice will be given to you no later than 24 hours after receiving the claim. You must be given a reasonable time to provide the information but not less than 48 hours. You will be notified of the decision

concerning your urgent care claim as soon as possible but no later than 48 hours after the earlier of:

- When the plan receives the requested information or
- The end of the period you were given to provide the information

Concurrent Care Claim

At times, the claim administrator may approve a course of treatment that is provided over time or for a specific number of treatments. If the claim administrator later terminates or reduces approval for a course of treatment, it will notify you of this decision so you will have sufficient time to appeal that decision before the course of treatment is reduced or terminated.

If you need to extend a course of treatment and the original request for the treatment was an urgent care claim, you should contact the claim administrator at least 24 hours before the approved course of treatment will expire. If you do so, the claim administrator will provide you with a notice of its decision concerning the requested extension within 24 hours of your request. If you request an extension later, you will receive notice of the claim administrator's decision based on whether that request is an urgent care or pre-service claim.

Appealing a Denial

If you disagree with an adverse determination, you may request a full review by the claim administrator. You must submit this request within 180 days after you receive the adverse determination. A rescission of coverage is treated as an adverse determination and may be appealed. In connection with your appeal, you or your representative can review relevant documents and submit issues and comments in writing. See page 22 for more information concerning relevant documents you can request. If you want to appeal a benefit decision for benefit level claims, send your appeal the claim administrator listed in the ***Administrative Information*** section of this handbook.

Your appeal will be reviewed and someone other than the person who made the first decision on your claim must make this review. The claim administrator must disclose the identity of any medical or vocational experts who were consulted in connection with your claim. If the benefit decision is based on a medical judgment, the claim administrator must consult with a health care professional who has the appropriate training and experience in the field of medicine involved.

If the claim administrator considers or relies upon any new or additional evidence in making the benefit decision, you will provided with this evidence, free of charge, as soon as possible and sufficiently in advance of the date the decision is made. If the claim administrator bases the benefit decision on any new or additional rationale, you will be provided with this rationale, free of charge, as soon as possible and sufficiently in advance of the date the decision is made.

After a decision is made concerning your appeal, you will be notified of its findings and decision in writing. This notice will be provided no later than:

- For an urgent care claim, 72 hours after receiving the appeal
- For a pre-service claim, 30 days after receiving the appeal
- For a post-service claim, 60 days after receiving the appeal

Claims Decisions Notices

The notice given to you concerning the decision on either your initial claim or your appeal will include:

- The specific reason or reasons for the decision
- The specific plan provisions upon which the benefit decision is based
- The denial code and its corresponding meaning, as well as a description of the plan's standard, if any, used in the decision
- Information sufficient to identify the claim involved, including the date of service, health care provider, a notice regarding the availability of the diagnosis and treatment codes and their corresponding meanings, upon request, and claim amount (if applicable)
- A description of any additional material or information that is necessary for you to complete your claim and an explanation of why such material or information is necessary
- If an internal rule, guideline, protocol or similar criterion was relied on in making the decision, either a copy of that document, or a statement that such a document was relied upon and that a copy will be furnished (free of charge) upon request
- If the decision is based on a medical limit (for example, a decision that the proposed service is not medically necessary or that it is experimental), either an explanation of the scientific or clinical judgment for the decision (applying the plan's terms to your medical circumstances), or a statement that such an explanation will be provided free of charge upon request
- A statement disclosing the availability of, and contact information for, any applicable consumer assistance office or ombudsman established to assist individuals with claims and appeals and the external review process
- For an initial claim, a description of the appeal procedures
- For an appeal, a description of the external review procedures
- For an appeal, a statement describing your right to bring a civil action under section 502(a) of ERISA following the denial of your appeal

External Review Procedures

If you disagree with the decision concerning your appeal, you may be eligible to request an external review of your claim. To be eligible for an external review, you must:

- Have been covered under the plan when the service was requested/provided
- Exhausted the plan's claims and appeals procedures, listed above
- Have a claim that relates to a question of medical judgment or a rescission of coverage, and
- Have provided all information and documentation required to process external review

If you are eligible to file a request for external review, you must send your request to the claim administrator listed in the ***Administrative Information*** section of this handbook within four months of receiving the adverse decision concerning your appeal. The external review will be assigned to an independent review organization (IRO). If you believe an expedited external review is necessary to avoid jeopardizing your life or health, you must file a request for an expedited review with the claim administrator.

Life and Accidental Death & Dismemberment (AD&D)

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While you are working, you and your dependents rely on your paycheck to meet day-to-day expenses. If you die or are seriously injured in an accident, your dependents' financial security could be seriously affected.

As part of your WM benefits program, you have access to life and AD&D coverages designed to assist during these difficult times.

If You Have Questions

If you have questions about your life and AD&D coverage, please contact the Benefit Center at 800-964-3373.

As you read about the life and AD&D coverage options, keep the following in mind:

- **Basic Employee Life and AD&D –** The Company automatically provides you with basic employee life and AD&D coverage. Your designated beneficiary is eligible for life insurance benefits if you die for any reason. If you die as a result of an accident, your designated beneficiary is eligible for AD&D benefits. These are in addition to any optional employee life insurance benefits that may be available. If you suffer certain accident-related injuries that result in paralysis or covered loss, you are eligible for AD&D benefits.

  The Company pays the full cost of this coverage.

- **Optional Employee Life and AD&D –** In addition to the Company-provided basic employee life and AD&D coverage, you may purchase optional employee life and AD&D coverage for yourself. This coverage provides additional protection to your beneficiary in the event of your death. It also pays you an additional benefit if you suffer an accident-related injury that results in paralysis or covered loss.

  You pay for this additional coverage with after-tax dollars deducted from your paycheck.

- **Basic Dependent Life and AD&D –** The Company pays the full cost to provide your eligible dependents with basic life and AD&D coverage ($5,000 spouse; $2,500 each child), but you must enroll them. If you do not, you will not receive the company-paid dependent basic life and AD&D insurance coverage. This coverage pays a benefit if your spouse or child dies or experiences a covered loss due to an accident-related injury. If you and your spouse both work at the Company and both of you are eligible to participate, you each are covered as an employee and cannot also be covered as a dependent spouse. In addition, your eligible dependent children may only be covered by one parent.

  The Company pays the full cost of this coverage.

- **Optional Dependent Life and AD&D –** In addition to the Company-provided basic dependent life and AD&D coverage, you may purchase optional dependent life and AD&D coverage for your spouse and/or dependent children. As the beneficiary, this coverage provides you with additional financial protection in the event of your spouse's or child's death. It also pays you a benefit if your spouse or child suffers certain accident-related injuries that result in paralysis or covered loss.

  You pay for this coverage with after-tax dollars deducted from each paycheck. If you purchase optional dependent life insurance coverage for your children, all of your children are covered at a single rate, regardless of the number of children you have.

A Snapshot of the Life and AD&D Coverages

The following chart is a snapshot of the life and AD&D coverage options available to you and your dependents.

Life Insurance Coverages

Life Insurance	Coverage Available	
Basic Employee Life		
Hourly and Salaried Employees	1 Times Annual Pay ($25,000 minimum pay)	
Incentive-Paid Employees	$45,000	
	Maximum Coverage Amount: $4,000,000 ($2,000,000 for each life and AD&D coverage)	
Optional Employee Life*		
Hourly and Salaried Employees	1 Times Annual Pay 2 Times Annual Pay 3 Times Annual Pay 4 Times Annual Pay 5 Times Annual Pay 6 Times Annual Pay 7 Times Annual Pay 8 Times Annual Pay	
Incentive-Paid Employees	1 Times Pay ($45,000) 2 Times Pay ($90,000) 3 Times Pay ($135,000) 4 Times Pay ($180,000) 5 Times Pay ($225,000) 6 Times Pay ($270,000) 7 Times Pay ($315,000) 8 Times Pay ($360,000)	
	Maximum Coverage Amount: $4,000,000 ($2,000,000 for each life and AD&D coverage)	
Basic Dependent Life	$5,000 spouse	$ 2,500 per child
Optional Dependent Life**	$10,000 spouse $20,000 spouse $30,000 spouse $40,000 spouse $50,000 spouse $60,000 spouse $70,000 spouse $80,000 spouse $90,000 spouse $100,000 spouse	$ 5,000 per child $10,000 per child $25,000 per child

*Evidence of insurability may be required.
**You must purchase optional employee life insurance coverage to elect optional dependent life insurance coverage. In addition, your spouse's coverage cannot be more than 50% of your optional employee life coverage amount. Evidence of insurability may be required for your spouse's coverage.

AD&D Insurance Coverages

AD&D Insurance	Coverage Available
Basic Employee AD&D	Equal to Basic Employee Life
Optional Employee AD&D*	Equal to Optional Employee Life
Basic Dependent AD&D	Equal to Basic Dependent Life
Optional Dependent AD&D**	Equal to Optional Dependent Life

* Evidence of insurability may be required.
**You must purchase optional employee AD&D coverage to elect optional dependent AD&D coverage for your dependents. Your spouse's coverage cannot be more than 50% of your optional employee AD&D coverage. Evidence of insurability may be required for your spouse's coverage.

Annual Pay

Your annual pay determines the following coverages:

- Basic employee life and AD&D
- Optional employee life and AD&D

"Annual pay" means your hourly rate as of August 1 of the previous plan year times 40 hours times 52 weeks – or your base pay plus eligible commissions (as of August 1). It does not include bonuses or overtime pay. If you are an "incentive-paid" employee, your annual pay is considered to be $45,000.

If your annual pay increases, the total amount of your life and AD&D insurance coverages increase(s) the following January (provided you are actively at work on that day). Any contributions you make toward the cost of these coverages may increase effective each January 1. If you increase coverage during annual enrollment, the coverage is based on the amount of your annual pay as of the prior August 1.

How the Life and AD&D Coverages Work

This section provides a brief overview of how the life and AD&D coverages work.

Choosing Your Coverage Options

When you are first hired, and each year during annual enrollment, you select the coverage option you need for yourself and your eligible dependents. The following life and AD&D coverage options are available:

- Optional employee life and AD&D
- Optional dependent life and AD&D

Please note: If you want optional dependent life and AD&D coverage, you must select optional employee life and AD&D coverage. In addition, optional coverage for your spouse cannot be more than 50% of your optional employee life and AD&D coverage.

See the snapshot charts starting on page 91 for the coverage amounts associated with each option.

Naming a Beneficiary

A beneficiary is someone who receives benefits in the event of your death.

When you enroll, you must select a coverage option and name a beneficiary. To designate a beneficiary, log on to mywmtotalrewards.com or call the Benefits Center. You are automatically the beneficiary for your dependent's basic and optional life and AD&D coverages. You cannot name any other beneficiary for those coverages. If you assign benefits, you and your spouse should contact your legal counsel for guidance. If you die, dependent coverages end.

You can name one or more beneficiaries. If you name more than one beneficiary, you need to designate what portion of the entire benefit should be paid to each. If you fail to provide a percentage when naming multiple beneficiaries, the benefit is paid in equal shares to each then living beneficiary. You also need to indicate the beneficiaries' relationships to you.

Changing Your Beneficiary

Because family situations can change, you should review your beneficiary designations from time to time. You may change your beneficiary at any time by logging on to mywmtotalrewards.com or contacting the Benefits Center. You do not need the beneficiary's consent to make this change. Your new designation takes effect on the date you make the change.

If You Do Not Name a Beneficiary

If you do not name a beneficiary (or if your beneficiary dies before, at the same time as, or within 24 hours of your death), the benefit is paid in one lump sum to those below in the following order:

- Your surviving legal spouse, or if none
- Your surviving legal child(ren) (in equal shares), or if none
- Your surviving parent(s) (in equal shares), or if none
- Your surviving sibling(s) (in equal shares), or if none
- Your estate

Beneficiary Assignment

Your beneficiary may assign the life and AD&D insurance proceeds to anyone. For example, the beneficiary may want to assign a portion of the life insurance benefit to a funeral home to cover funeral expenses. To assign benefits, beneficiary(ies) should sign the assignment, include the amount, and provide your name and Social Security number to MetLife. MetLife keeps a copy of any beneficiary assignment on file. For the full address of the carrier, see page 103.

Viatical Settlement

In the event you are terminally ill and were diagnosed by your physician as having less than a year to live (for Texas residents, less than two years to live), you may assign your rights to your life insurance coverage to a viatical settlement company in exchange for a current cash payment of a portion of the death benefits.

Such assignment transfers all rights, title, interest, and incidents of ownership of such benefits, including the:

- Right to make contributions to keep benefits active
- Privilege of obtaining an individual life insurance policy
- Right to change the beneficiary

Evidence of Insurability

When you choose certain amounts of optional employee life and AD&D insurance for yourself, you must provide evidence of insurability. Evidence of insurability must be provided if:

- At your initial enrollment as a new hire, you elect optional employee life and AD&D that exceeds the lower of three times your annual pay or $750,000
- Any time you elect to increase your optional employee life and AD&D coverage by more than one level or so that it exceeds the lesser of five times your annual pay or $750,000 (evidence of insurability is not required when your coverage increases to more than $750,000 solely because of an increase in your annual pay)
  - For example, assume your annual pay is $249,000 and you currently have coverage equal to three times your pay ($747,000 of optional coverage). If your annual pay increases to $251,000, your optional coverage will automatically increase to $753,000 ($251,000 times 3). In this situation, evidence of insurability is not required because your increase in coverage to more than $750,000 is solely due to your increase in annual pay
  - However, assume your annual pay is $249,000 and you currently have coverage equal to three times your pay ($747,000 of optional coverage). If your annual pay stays the same but you elect to increase your coverage to four times your pay ($996,000 of optional coverage), then evidence of insurability is required because your increase in coverage to over $750,000 is due to an increase in the level of coverage you elected, not an increase in your annual pay

Evidence (Proof) of Insurability

If you elect optional life insurance coverage, you may be required to answer a health statement questionnaire. The questionnaire seeks medical information about you or your spouse, and must be completed by you and/or your physician. When evidence of insurability is required, coverage does not take effect until MetLife receives and approves the evidence of insurability.

If You Are Age 65 or Older

If you are age 65 or older and still actively working, your life and AD&D coverages (applies to all basic and optional employee and dependent coverages) is reduced starting at age 65. The percentage reduction is applied to the coverage in effect on the day before your 65th birthday. The chart below shows the percentage of coverage that remains at each age.

Age	Percentage Remaining*
65-69	60%
70-74	40%
75-79	25%
80 and older	15%

*The percentage is applied to the coverage in effect on the day before your 65th birthday.

If You Retire

All life and AD&D coverages for you, your spouse, and your child(ren) end on the day you retire. For information on converting your life and AD&D coverage to an individual policy, see page 102.

Imputed Income (GTL)

Under current tax laws, you are required to pay income taxes on the "value" of your Company provided basic employee life insurance coverage over $50,000. The "value" is determined by your age and according to a schedule established by the Internal Revenue Service (IRS). This tax liability is called "imputed income." **In addition, current tax law requires you to pay income taxes on the "value" of Company-provided basic dependent life insurance coverage.** These amounts are added to your gross wages and are included on your W2 Form at the end of the calendar year.

Because you pay for optional employee and dependent life insurance coverages with after-tax dollars, imputed income does not apply and no additional amount is added to your taxable wages.

Life Insurance

Your life insurance coverage options are highlighted in the snapshot chart on page 91. Additional information on these coverages follows.

Basic Employee Life Insurance

As long as you are actively at work for one full day on or after the date you meet the eligibility requirements, you automatically receive basic life insurance coverage. The Company pays the full cost of this coverage. For information on eligibility, please see page 6 of the ***Participation*** section. You are eligible for basic life insurance equal to one times your annual pay (minimum $25,000).

Coverage amounts are rounded up to the next $1,000. If you are an incentive-paid employee, your pay is considered to be $45,000, so the coverage amount is one times that amount, or $45,000. See pages 91-92 for additional information on annual pay.

If you die while you have this coverage, your designated beneficiary is eligible for this benefit. The maximum basic employee life insurance coverage you can receive is $2,000,000.

Optional Employee Life Insurance

You may decide you want more coverage than your basic life coverage provides. If you do, you may purchase optional coverage for yourself equal to:

- 1 times your annual pay or $45,000 for incentive paid employees
- 2 times your annual pay or $90,000 for incentive paid employees
- 3 times your annual pay or $135,000 for incentive paid employees
- 4 times your annual pay or $180,000 for incentive paid employees
- 5 times your annual pay or $225,000 for incentive paid employees
- 6 times your annual pay or $270,000 for incentive paid employees
- 7 times your annual pay or $315,000 for incentive paid employees
- 8 times your annual pay or $360,000 for incentive paid employees

See pages 91-92 for details on how annual pay is determined. The maximum optional employee life insurance you can receive is $2,000,000.

If you purchase this coverage and you die while covered, your designated beneficiary for optional life receives the life insurance benefits.

If you purchase optional employee life insurance coverage, you may have to provide evidence of insurability. See page 94 for details on when evidence of insurability is required.

Please note: As a new hire, you can elect up to the lower of three times your annual pay or $750,000 in optional employee life insurance coverage without providing evidence of insurability. After your initial enrollment, you can increase your optional employee life insurance coverage. However, evidence of insurability is required for increases greater than one level or to more than the lesser of five times your annual pay or $750,000. Evidence of insurability is also required if you do not elect optional employee life insurance coverage when you are first eligible and then decide to elect it during a later enrollment opportunity.

You pay for optional employee life insurance coverage with after-tax dollars deducted from each paycheck.

Exclusion: Your beneficiary will not receive optional employee life insurance benefits if you commit suicide, while sane or insane, within two years of the effective date of your optional employee life insurance coverage. If you commit suicide, while sane or insane, more than two years after the effective date of your optional employee life insurance coverage but within two years of the effective date of any increase in the amount of your optional employee life insurance coverage, your beneficiary will not receive that amount. Instead, your beneficiary will receive optional life insurance benefits equal to the sum of:

- The contributions paid for the increased amount (without interest)
- The employee optional life insurance coverage level in effect on the day before the increased amount became effective

Basic Dependent Life Insurance

As long as you are actively at work for one full day on or after the date you meet the eligibility requirements, the Company automatically provides basic life insurance coverage for your spouse and your child(ren), as shown below, if you enroll them in this coverage by calling the Benefits Center or enrolling them online at mywmtotalrewards.com.

- Spouse $5,000
- Child(ren) $2,500

Because you are the beneficiary, you automatically receive the life insurance benefits if your covered spouse or child dies. In addition, you do not have to pay for this coverage. The Company pays the full cost of this coverage on your behalf.

Eligible Dependents

See pages 6-7 of the ***Participation*** section for a definition of who is eligible for dependent life (basic and optional) insurance coverages. Special rules apply in Louisiana (see page 7). Be sure to notify the Benefits Center if your covered spouse or child no longer meets the eligibility requirements.

Optional Dependent Life Insurance

In addition to the Company-provided basic coverage, you can purchase additional optional dependent life insurance coverage for your spouse and/or your child(ren), as shown in the chart below.

Spouse*	Child(ren)
$10,000	$ 5,000 (per child)
$20,000	$10,000 (per child)
$30,000	$25,000 (per child)
$40,000	
$50,000	
$60,000	
$70,000	
$80,000	
$90,000	
$100,000	

*Evidence of insurability may be required for your spouse. It is not required for your children.

You can only purchase optional dependent life insurance coverage for your spouse and child(ren) if you purchase optional employee life insurance coverage for yourself. Optional dependent life insurance coverage for your spouse cannot exceed 50% of your optional employee life insurance coverage. Because you are the beneficiary, if you purchase this coverage, you receive both basic and optional dependent life insurance benefits payable in the event of the death of your covered spouse or child. As a result, this coverage provides you with additional protection in the event of your covered spouse's or child's death for any reason.

An Example—Spouse Life Insurance Coverages (Basic and Optional)

To show how basic and optional spouse life insurance coverage works, assume that your spouse has the following life insurance coverages:

Basic spouse life insurance coverage	$ 5,000
Optional spouse life insurance coverage	$30,000

If your spouse dies from natural causes or an illness, you receive a tax-free life insurance benefit of:

Basic dependent life insurance coverage	$ 5,000
Optional dependent life insurance coverage	$30,000
TOTAL:	$35,000

If your spouse dies from an accident-related injury and has dependent AD&D coverage (basic and/or optional), you receive AD&D benefits in addition to the life insurance benefits. See page 99 for details.

Evidence of Insurability

As a new hire, you can elect up to $30,000 of optional spouse coverage without providing evidence of insurability. After your initial enrollment, you can increase your optional dependent life insurance coverage; however, your spouse must provide evidence of insurability for increases greater than one level or to any amount greater than $30,000. This requirement also applies if you change your coverage during the year because of qualified change in marital status. Evidence of insurability is also required if you do not elect optional dependent life insurance coverage for your spouse when you are first eligible and then decide to elect it during a later enrollment opportunity.

Please note: Evidence of insurability is not required for optional child life and AD&D coverage. You pay for this coverage through after-tax dollars deducted from each paycheck. If you purchase this coverage for your children, all of your children are covered at a single rate, regardless of the number of children you have.

AD&D Coverage

Your AD&D coverage is highlighted in the snapshot chart on page 91. Remember, AD&D insurance is linked to life insurance and is automatically provided with Company-paid basic life insurance coverage. If you purchase optional employee and dependent life insurance, you will also have optional employee and dependent AD&D insurance.

The Coverage

Your AD&D coverage pays benefits to your beneficiary if you die as a result of an accident. This is in addition to any basic or optional employee life insurance benefits that may be available. You also may receive AD&D benefits (basic and optional) if you suffer a covered loss due to an accident-related injury (e.g., you lose your sight, a hand, a foot or you experience another covered loss, as shown on page 100). You also receive AD&D benefits (basic and optional) if your covered spouse or dependent dies or suffers a covered loss due to an accident-related injury. A brief description of each coverage follows.

Basic Employee AD&D

This coverage comes with your Company-provided basic life coverage and equals the amount of that coverage. The Company pays the full cost of this coverage.

Optional Employee AD&D

You receive additional AD&D coverage when you purchase optional life insurance coverage. Optional employee AD&D coverage cannot be purchased separately from optional employee life insurance coverage. You pay for this additional coverage with after-tax dollars deducted from each paycheck.

Basic Dependent AD&D

This coverage for your spouse and/or child(ren) equals your spouse’s and/or child’s basic dependent life insurance coverage. The Company automatically provides this coverage and pays the full cost if your dependents are enrolled.

Optional Dependent AD&D

You receive additional AD&D coverage for your spouse and/or child(ren) when you purchase optional dependent life insurance coverage for them. Optional dependent AD&D coverage cannot be purchased separately from optional dependent life insurance coverage. You pay for this coverage with after-tax payroll deductions. If you purchase optional dependent AD&D coverage, all of your children are covered at a single rate, regardless of the number of children you have.

An Example – Dependent AD&D Coverage (Basic and Optional)

To show you how basic and optional dependent AD&D coverage works (and to show how it works with the dependent life insurance coverages), assume that your spouse has the following life and AD&D coverages:

Basic dependent life insurance coverage	$ 5,000
Optional dependent life insurance coverage	$30,000
Basic dependent AD&D insurance coverage	$ 5,000
Optional dependent AD&D insurance coverage	$30,000

If your spouse dies from an accident-related injury, you receive a tax-free life and AD&D benefit of:

Basic dependent life insurance coverage	$ 5,000
Optional dependent life insurance coverage	$30,000
Basic dependent AD&D insurance coverage	$ 5,000
Optional dependent AD&D insurance coverage	$30,000
TOTAL	$70,000

Eligibility for AD&D Benefits

To be eligible for AD&D benefits, all of the following requirements must be satisfied:

- ➤ You or your covered dependent must be involved in an accident while coverage is in effect
- ➤ The accident must be the sole cause of the injury
- ➤ The injury must be the sole cause of the covered loss (covered losses are shown in the schedule)
- ➤ You or your covered dependent must have experienced the covered loss within one year after the accident date

Covered AD&D Losses

The chart below highlights the schedule of benefits if you (or a covered dependent) experience a covered loss after an accident.

Schedule of Covered AD&D Losses

Covered Loss	Percent of Coverage	Amount Payable
Life	100%	To beneficiary
Sight in both eyes	100%	To you
Both hands	100%	To you
Both feet	100%	To you
One hand and one foot	100%	To you
One hand or one foot and sight in one eye	100%	To you
Speech and hearing	100%	To you
Paralysis of four limbs	100%	To you
Paralysis of three limbs	75%	To you
Paralysis of two limbs	66%	To you
Paralysis of one limb	50%	To you
Speech or hearing in both ears	50%	To you
One hand	50%	To you
One foot	50%	To you
Sight in one eye	50%	To you
Thumb and index finger on the same hand	25%	To you

In the event of multiple losses from one accident, you receive AD&D benefits up to the full coverage amount. Once the full benefit is paid, losses from the same accident that occur later and losses from any future accident are not covered.

Losses Defined

The plan defines covered losses as:

- Loss of sight – the complete loss of sight that cannot be restored or corrected
- Loss of hands or feet – the hand is cut off at or above the wrist, or the foot is cut off at or above the ankle
- Loss of speech – the complete and irrevocable loss of speech that lasts continuously for 12 consecutive months following the injury
- Loss of hearing – the complete and irrevocable loss of hearing that lasts continuously for 12 consecutive months following the injury
- Loss of a thumb – the actual severance through or above the second joint from the tip of the thumb
- Loss of an index finger – the actual severance through or above the third joint from the tip of the index finger
- Paralysis – the total loss of use (without severance) of a limb. A medical authority must determine the paralysis to be permanent, complete, and irreversible

Special Benefits

The information below highlights the special benefits available under your and your dependents' AD&D coverages (basic and optional).

Exposure Benefit

If you or a covered dependent dies due to unavoidable exposure to the elements, the beneficiary receives 100% of the AD&D benefit. The beneficiary receives this special benefit provided your (or your covered dependent's) body is not found within one year after the conveyance in which the covered individual was traveling either:

- Disappeared
- Made a forced landing
- Sank
- Was wrecked

Seat Belt Benefit

This seat belt benefit only applies to the basic AD&D coverage and does not apply to any optional AD&D coverage. The beneficiary receives an additional 100% of the AD&D basic coverage amount (up to $100,000) if you or your covered dependent dies as a result of an accident and the covered individual was wearing a properly fastened seat belt (subject to police verification).

A seat belt is any child restraint device that complies with state law. A seat belt is also any other restraint device that meets published federal safety standards, was installed by the car manufacturer, and was not altered after such installation.

If you (or your covered dependent) were driving under the influence of alcohol or other drugs, you or your beneficiary is not eligible for this special benefit.

Exclusions

You (or your beneficiary) do not receive AD&D benefits for any loss that results from or is caused or contributed to by any of the following:

- A physical or mental illness (including the diagnosis and treatment of such illness)
- An infection, unless it is caused by an external visible wound and was sustained in an accident
- A suicide or attempted suicide
- Intentional injury to oneself
- The use of any drug or medicine as defined by United States federal or state law, unless use is based on a doctor's advice
- War or warlike action in time of peace (includes terrorist acts)
- Commission or attempted commission of a felony or other serious crime or assault
- Any poison or gas that is taken, administered or absorbed voluntarily
- Service in the armed forces of any country or international authority (except for service as a member of the Armed Forces, organized Reserve Corps of the United States or United States National Guard)
- Operation of an aircraft, instruction in the operation of an aircraft, or service as an aircraft crew member (other than serving as a pilot or crew member of an aircraft owned or leased by, or on behalf of, WM or any subsidiary or affiliate of WM) for the purpose of transporting passengers on behalf of WM or any subsidiary or affiliate of WM; or while in any aircraft operated by or under any military authority (other than the Military Aircraft Command); or while in any aircraft being used for a test or experimental purposes; or while in an aircraft used or designed for use beyond the earth's

atmosphere; or while in any aircraft for the purposes of descent from such aircraft while in flight (except for self-preservation)
- Driving a vehicle while intoxicated (as defined by the laws of the jurisdiction in which the vehicle is operated)

Situations Affecting Your Life and AD&D Coverages

Certain situations could affect your life and AD&D coverages. For additional information on how long these coverages continue, see page 17 of the ***Participation*** section.

Converting to an Individual Policy

You (or your covered dependent) may be able to convert your group life insurance coverages (basic and optional) to an individual policy. You are eligible for conversion coverage if any of the following occurs:

- Your employment ends
- You are (or your covered dependent is) no longer eligible for coverage
- The coverage under the plan ends (provided you've been covered under the plan for at least five years)

You (or your covered dependent) pay the cost of conversion coverage, which is issued by the insurance carrier. You (or your covered dependent) do not have to provide evidence of evidence of insurability if conversion to an individual policy takes place within 31 days of when coverage ends. If you (or your covered dependent) die during the 31-day conversion period, your beneficiary (or you) is entitled to receive benefits at the same coverage amount as if you (or your dependent) had changed to an individual policy on the day before death.

You must apply with the insurance carrier (currently MetLife) for conversion and make the required premium payment before the later of:

- 31 days after the day coverage ends
- 15 days after the day a notice is given, if the notice is given more than 15 days from the day coverage ends, but not more than 91 days after the day coverage ends

Portability

You (or your covered dependent) can transfer existing optional group life insurance coverage to another group policy with the insurance carrier (currently MetLife). You are eligible for portable coverage if any of the following occurs:

- Your employment ends
- You are (or your covered dependent is) no longer eligible for coverage

You (or your covered dependent) pay the cost of the portable coverage, which is issued by the insurance carrier. You (or your covered dependent) do not have to provide evidence of insurability. The cost of portable coverage will depend on your (or your covered dependent's) age and may be different than what you paid for the optional WM coverage.

You must apply with the insurance carrier (currently MetLife) for portable coverage and make the required premium payment before the later of:

- 31 days after the day coverage ends
- 45 days after the day a notice is given, if the notice is given more than 15 days from the day coverage ends, but not more than 90 days after the day coverage ends

If you (or your covered dependent) die during the 31-day period after the WM coverage ends and before MetLife receives the portability application, your beneficiary (or you) is entitled to receive benefits at the same coverage amount as if you (or your dependent) had converted to an individual policy on the day before death.
If you (or your covered dependent) elect the portability option, the minimum coverage level is:

- $20,000 for you
- $2,500 for your spouse
- $1,000 for your child(ren)

If you (or your covered dependent) elect the portability option, the maximum coverage level is the lesser of:

- The optional coverage in effect when the WM coverage ends
- $1,000,000

Contact Information

Metropolitan Life Insurance Company
One Park Plaza, Suite 1150
Irvine, CA 92614

If you have questions about your life and AD&D coverage, contact the Benefit Center at 800-964-3373.

Applying for Benefits

If you or a covered dependent dies or if you are seriously injured in an accident, you or your beneficiary should notify the Benefits Center as soon as possible. You (or your beneficiary) must submit the appropriate claim form and, if applicable, death certificate to receive life and/or AD&D benefits. Otherwise a delay in payment may occur.

How to File Claims

If you or a covered dependent dies, the beneficiary should file a claim as soon as possible. Each beneficiary should submit a claim.

For AD&D benefits, you (or your beneficiary) must file a claim and proof of the loss within 90 days of the accident or loss. While a claim is pending, you or your covered dependent may be asked to be examined by a doctor of the carrier's choice (at the carrier's expense). In the case of death, an autopsy may be performed.

Claim Filing Deadline

You have up to one year from the date of illness, accident, or death to file your claim for payment. Claims filed or received after one year are not eligible for benefits.

Special Payment Options

You or your beneficiary can elect to receive the life and/or AD&D benefits as:

- A lump-sum payment
- Installment payments (monthly, quarterly, semiannual or annual payments)

Accelerated Benefit

If you become terminally ill while your life insurance is in effect, you may ask to receive an accelerated death benefit. Your accelerated death benefit equals the lesser of:

- 50% of your basic and optional employee life insurance amounts
- $250,000

The remainder of your life insurance benefits is then paid to your beneficiary at the time of your death. Your coverage is determined as of the date you meet the requirements for this benefit. If your life insurance coverage is scheduled to reduce (based on the schedule shown on page 94) within six months, your accelerated death benefit equals 50% of such reduced amount.

Eligibility for Accelerated Benefit

You are eligible for the accelerated benefit if your doctor certifies that your life span is drastically limited, your life expectancy is 12 months or less (24 months for Texas residents) due to your terminal illness and you are not expected to recover. You receive benefits if you satisfy all of the following:

- You are less than 63 years of age when you apply for accelerated benefits
- You apply for the accelerated benefit while you are covered
- You meet the above requirements

The accelerated benefit is a voluntary option. It is payable only once and it reduces the amount available for you to convert to a personal policy of life insurance. Generally, benefits provided under this provision are exempt from federal income taxes. However, you should consult your tax advisor regarding possible tax implications.

If you become terminally ill and need to exercise this living benefit option, contact MetLife.

Exclusions

You are not eligible for an accelerated benefit if:

- You assign your life benefits
- Your life insurance benefit is less than $10,000

When Benefits Are Paid

Benefits are paid on the basis of coverage in effect. They are paid as of the date of death for:

- Basic employee life
- Optional employee life
- Basic dependent life
- Optional dependent life
- Basic employee AD&D (in the event of an accidental death)
- Optional employee AD&D (in the event of an accidental death)

- Basic dependent AD&D (in the event of an accidental death)
- Optional dependent AD&D (in the event of an accidental death)

They are paid as of the date of the accident for:

- Basic employee AD&D
- Optional employee AD&D
- Basic dependent AD&D
- Optional dependent AD&D

This applies even if the covered loss occurs after the actual date of the accident.

You (or your beneficiary) receive benefits as soon as administratively possible after MetLife receives satisfactory proof of death or loss.

Filing a Claim

Please refer to page 22 of the ***Participation*** section for more information on filing eligibility and enrollment claims.

If you (or you beneficiary) have any questions about benefits paid or denied, you (or you beneficiary) should contact the insurance company and try to work out the problem. If you are not satisfied with the response, you should send a written request for benefits to the insurance company. If the insurance company again denies your claim for benefits, it will send you a notice. This notice will include reference to the specific plan provision on which the benefit decision was based and a description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary. The notice will generally be given within 90 days unless the insurance company notifies you in writing that an extension (not to exceed 90 days) is needed.

If you believe the denial is still incorrect, you may request a full and fair review by the insurance company within 60 days after you received the notice. In connection with your appeal, you or your representative can review relevant documents and submit issues and comment in writing. See page 22 of the ***Participation*** section for details on the relevant documents that must be made available to you.

The insurance company will review all disputed claims and will notify you of its findings and decision in writing within 60 days (unless special circumstances require an extension not to exceed an additional 60 days) after it receives the appeal. Your notification will include reasons for the decision and references to the plan provision on which the decision is based.

Disability

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Your disability coverage is designed to help ensure that you continue to receive income if you are unable to work because of an illness or non-work related injury.

The WM benefits program offers two disability coverages: short-term disability (STD) and long-term disability (LTD). As you read about these coverages, keep the following in mind:

If You Have Questions

If you have questions about your disability benefits, call 877-216-8677.

- As long as you are actively at work for at least one full day on or after the date you meet the eligibility requirements, you automatically receive STD and LTD coverage. For example, if you become disabled on your 60th day of employment, you will not be entitled to disability benefits because you have not completed 90 days of employment. If you remain disabled and unable to work for 40 additional days and then return to work, you must work for 31 more days (so you will have reached 91 days of employment) before you will be eligible for benefits (if you meet the other requirements of this section). For information on eligibility and when coverage ends, please see the ***Participation*** section.
- If you are injured or become ill while on a leave of absence from WM, you will not receive STD benefits. Therefore, you must be "actively at work" or on a vacation the regularly scheduled day prior to your application for STD.
- If you become disabled due to an illness or non-work related injury and qualify for benefits, you receive STD benefits, assuming you satisfy all other provisions of the plan
- After you use up your STD benefits, you may be eligible for LTD benefits
- Your monthly LTD benefits continue until you reach retirement age (defined as the Social Security Normal Retirement Age), or you are no longer disabled (whichever occurs first)
- Your LTD benefits coordinate with other sources of disability income – such as Social Security and workers' compensation – to continue a percentage of your base pay

Your Short-Term Disability (STD) Coverage

If you become disabled and are eligible for STD benefits, you continue to receive a percentage of your base pay. WM pays the full cost of this coverage.

Please note: This program is not subject to ERISA.

Disability Defined

Under the STD coverage, a disability must prevent you from performing your current occupation. To be disabled for this purpose because of an illness or injury, you must satisfy all of the following requirements:

- An accidental bodily injury, sickness, mental illness, substance abuse or pregnancy must continuously make you unable to perform one or more of the essential duties of your own occupation
- You must be under the regular care of a licensed physician (other than yourself, if you are a physician, and not related to you)

Elimination Period

STD benefits begin on the eighth day of an illness (the seven-day waiting period includes weekends), or the first day of a non-work related accident.

How STD Coordinates with Your Paid Time Off

Before STD benefits begin, you may use your paid time off (if available).

STD Benefits for Salaried Employees

If you are a salaried or office/clerical hourly employee, your weekly STD benefit equals 100% of your base pay for the first eight weeks of disability, excluding the elimination period. For the next 18 weeks of disability, your benefit equals 60% of your base pay (for a total of 26 weeks). Benefits end when you receive 26 weeks of STD benefits, once you are no longer disabled (whichever occurs first), or if your employment with WM is terminated.

Example

To show how the plan calculates your STD benefit, assume that you are a regular salaried employee whose weekly base pay is $400. Also assume that you are off work for 10 consecutive weeks due to an illness. (You may use your accumulated paid time off to cover the first seven calendar days of your illness.) The plan calculates your STD benefit as shown below.

$400 x 100% = $400 (weekly STD benefit for the first eight weeks after your elimination period)
$400 x 60% = $240 (weekly STD benefit for the remaining week)

Elimination Period

The period of time you must wait before your STD benefits begin.

Base Pay

Your base pay is your average annual rate of pay. It includes any contributions you make toward the benefits program, as well as any commissions you were paid during the immediate 12-month period leading up to your disability. (If you have been with the Company less than 12 months, then your base pay includes any commissions you were paid during your entire period of employment with the Company.) For incentive-paid employees, base pay is determined by averaging your base pay over the last 12 months (it will be prorated if you have been with the Company less than 12 months). Your base pay does not include bonuses, overtime, or any expense reimbursements you may receive.
Your weekly base pay is determined by multiplying your hourly base pay (as defined above) by the number of weekly scheduled hours for your position.

STD Benefits for Hourly Employees

If you are an hourly employee, your STD benefit is 60% of your pay for up to 26 weeks. Benefits end when you receive 26 weeks of STD benefits, once you are no longer disabled (whichever occurs first), or if your employment with WM is terminated.

Example

To show how the plan calculates your STD benefit, assume that you are a regular hourly employee whose weekly base pay is $640. Also assume that you are off work for 10 consecutive weeks due to an illness. (You may use your accumulated paid time off to cover the first seven calendar days of your illness.) The plan calculates your STD benefit as shown below.

$16 x 40 hours = $640 (weekly base pay)
$640 x 60% = $384 (weekly STD benefit for the nine weeks after your elimination period)

When Benefits Begin

STD benefits for all employees begin on the eighth day of disability if your disability is caused by an illness (you may use your accumulated paid time off to fill in the seven days in between). If your disability is caused by a non-work related accident, STD benefits begin on the first day of disability.

How Benefits Are Paid

You will receive your STD compensation in the same way you are currently paid. The amount you receive is subject to normal federal income and Social Security taxes.

Other Disability Benefits

Your STD benefits are offset by any other sources of disability income you may receive (e.g., automobile insurance or another third party that may pay you for your loss of income). See page 112 for details on other sources of disability income.

When Benefits End

Your STD benefits end once you are no longer eligible for coverage (no longer employed by WM), no longer disabled, or after you receive disability benefits for 26 weeks, whichever comes first. In addition, your STD benefits may end if your doctor releases you to return but you refuse work (offered by WM) that you are able to perform and for which you will be paid the same or a similar rate of pay.

STD benefits will not be payable if you are identified for but refuse to participate in a health coaching program.

If you are still disabled after 26 weeks and are eligible for LTD benefits, your LTD benefits pick up where your STD benefits leave off.

If You Return to Work

You may return to work on a part-time or full-time basis. Here is what happens to your STD benefits if you return to work:

- Part-time – If you return to work part-time while you are receiving STD benefits, you may still be entitled to STD benefits. However, your total pay cannot exceed 100% of your pre-disability earnings. Any pay you receive for sick pay, vacation pay, or other earnings cannot be substituted or earned at a level that would allow your pay (including your STD benefits) to exceed 100% of your pre-disability earnings. Therefore, your STD benefits may be reduced accordingly.
- Full-time – If you return to work full-time, and within 14 days of your return you become totally disabled from the same or a related cause, you continue to receive STD benefits as if it were the same claim – unless your second disability is due to an entirely unrelated cause.

STD benefits continue until you are no longer disabled, or until you receive disability benefits for a total of 26 weeks – whichever occurs first.

Your Long-Term Disability (LTD) Coverage

If you become disabled and are eligible for disability benefits, you continue to receive a percentage of your base pay. Your LTD coverage coordinates with other sources of disability income.

Your LTD Coverage

As a regular, benefits-eligible employee, your LTD coverage equals 60% of your base pay, up to a maximum monthly benefit of $25,000.

WM pays the full cost of your LTD coverage.

Definition of Disability/Disabled

The employee is considered disabled if, solely because of injury or sickness, he or she is:

- Unable to perform the material duties of his or her regular occupation during the elimination period or thereafter. For drivers only, this includes being unable to meet the driving requirements as outlined under the Department of Transportation regulations and
- Unable to earn 80% or more of his or her indexed earnings from working his or her regular occupation

After disability benefits have been payable for 24 months, the employees is considered disabled if, solely due to injury or sickness, he or she is:

- Unable to perform the material duties of any occupation for which her or she is, or may reasonably become, qualified based on education, training or experience and
- Unable to earn 60% or more of his or her indexed earnings

Own Occupation

Your occupation as it is recognized in the general workplace. It is not the specific job you perform for WM at your location.

Any Occupation

An occupation for which you are qualified or could become qualified by education, training, or experience and that has an earning potential greater than your indexed pre-disability earnings, 60% of your base pay, or the maximum benefits (whichever is less).

The insurance company will require proof of earnings and continued disability.

When Coverage Takes Effect

If a disabling condition causes you to be absent from work on the day your coverage is scheduled to begin according to the requirements on page 10 of the ***Participation*** section, coverage takes effect once you are actively at work for one full day after you satisfy the eligibility requirements.

Eligibility for Benefits

To receive LTD benefits, you must be unable to work because of a disability. You must provide medical proof of your disability when you first become disabled, and from time to time thereafter. This usually means having a medical examination or providing additional information on your condition upon request.

If you are not totally disabled, or if you refuse to be examined or to provide other satisfactory proof of disability, LTD payments end. In addition, if you fail to pass a physical exam that is required to maintain a license to perform the duties of your own occupation, it does not necessarily mean you are disabled.

Elimination Period

The elimination period is the period of time you must be disabled before LTD benefits become payable. Your elimination period is the later of:

- The first 180 consecutive days during any single period of disability (WM's current STD benefit period)
- With the exception of benefits required by state law, the expiration of any STD benefits or salary continuation program

Your LTD Benefits

Your monthly LTD benefit is generally 60% of your base pay.

Your LTD benefit coordinates with other sources of disability income you may be eligible to receive. Here is how it works:

- The disability benefit amount (60% of your base pay) is calculated
- Then, any other sources of disability income (for example, Social Security, workers' compensation, dependent benefits, and auto insurance) are subtracted from your disability benefit amount
- The result is your monthly WM LTD benefit

Example

To show how your monthly WM LTD benefit is calculated, suppose your monthly pay is $2,000. If you do not receive income from any other sources listed below, you receive a monthly LTD benefit of $1,200 (60% of $2,000).

If you qualify for Social Security or another source of disability income, your monthly WM LTD benefit is reduced by the amount of your other benefit. For example, if Social Security pays $600 a month, the LTD plan pays $600 a month – for a total of $1,200 a month, or 60% of your pay.

Elimination Period

The period of time you must wait before your LTD benefits begin.

Base Pay

Your base pay is your average annual rate of pay. It includes any contributions you make toward the benefits program, as well as any commissions you earn during the immediate 12-month period leading up to your disability. (If you have been with the Company less than 12 months, then your base pay includes any commissions you earn during your entire period of employment with the Company.) For incentive-paid employees, base pay is determined by averaging your base pay over the last 12 months (it will be prorated if you have been with the Company less than 12 months). Your base pay does not include bonuses, overtime, or any expense reimbursements you may receive.

If your base pay changes, your LTD coverage changes as of the date of your change (provided you are actively at work that day).

Other Sources of Disability Income

An employee for whom disability benefits are payable under this policy may be eligible for benefits from other income benefits. If so, the insurance company may reduce the disability benefits by the amount of such other income benefits. Other income benefits include:

- Any amounts received (or assumed to be received*) by the employee or his or her dependents under:
  - The Canada and Quebec Pension Plans
  - The Railroad Retirement Act
  - Any local, state, provincial or federal government disability or retirement plan or law payable for injury or sickness provided as a result of employment with the employer
  - Any sick leave or salary continuation plan of the employer
  - Any work loss provision in mandatory "No-Fault" auto insurance

- Any Social Security disability or retirement benefits the employee or any third party receives (or is assumed to receive*) on his or her own behalf or for his or her dependents; or which his or her dependents receive (or are assumed to receive*) because of his or her entitlement to such benefits.
- Any retirement plan benefits funded by the employer. "Retirement plan" means any defined benefit or defined contribution plan sponsored or funded by the employer. It does not include an individual deferred compensation agreement; a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan, or any employee savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 40l(k) plan
- Any proceeds payable under any group insurance or similar plan. If other insurance applies to the same claim for disability, and contains the same or similar provision for reduction because of other insurance, the insurance company will pay for its pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies
- Any amounts received (or assumed to be received*) by the employee or his or her dependents under any workers' compensation, occupational disease, unemployment compensation law or similar state or federal law payable for injury or sickness arising out of work with the employer, including all permanent and temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted
- Any amounts paid because of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined

Dependents include any person who receives (or is assumed to receive*) benefits under any applicable law because of an employee's entitlement to benefits.

If you could be eligible for other disability income from an individual insurance policy described above, mandatory no fault auto insurance or any settlement or judgment, or if you are in the process of appealing a Workers Compensation claim denial, you must sign and return a Subrogation Agreement before your benefit will be paid. For more information about subrogation, see the ***Subrogation and Reimbursement*** section, pages 16-17.

* The insurance company will assume the employee (and his or her dependents, if applicable) are receiving benefits for which they are eligible from other income benefits. The insurance company will reduce the employee's disability benefits by the amount from other income benefits it estimates are payable to the employee and his or her dependents. The insurance company will waive assumed receipt of benefits, except for disability earnings for work the employee performs while disability benefits are payable, if the employee:

- Provides satisfactory proof of application for other income benefits
- Signs a reimbursement agreement
- Provides satisfactory proof that all appeals for other income benefits have been made unless the insurance company determines that further appeals are not likely to succeed and
- Submits satisfactory proof that other income benefits were denied

The insurance company will not assume receipt of any pension or retirement benefits that are actuarially reduced according to applicable law, until the employee actually receives them.

Social Security Disability Payments

Once your application is approved, Social Security disability payments begin after a waiting period. However, the approval process can take several months, up to a year, or may never happen – so it is very important to apply for Social Security disability benefits as early as possible. A delay could mean that you lose those benefits. You can get information regarding eligibility for Social Security disability from any Social Security office.

Your LTD benefits coordinate with your Social Security disability payments when you first qualify for benefits. Any later increases in your Social Security payments do not affect your LTD payment. After you submit proof of loss, you are required to apply for Social Security disability benefits. You apply when the duration of your total disability meets the minimum-duration requirement under Social Security. If the Social Security Administration denies your eligibility for any such benefits, you are required to follow the process established by the Social Security Administration to reconsider the denial. If you are denied again, you can request a hearing before an administrative law judge of the Office of Hearings and Appeals.

Minimum and Maximum Benefits

The LTD payment, before all reductions for other sources of disability income, is 60% of your monthly base pay and could be zero after all deductions and reductions for other sources of disability income. The maximum LTD benefit is $25,000 per month.

LTD Benefit Payments

This section highlights when benefits begin, how long they continue, and when they end.

When Benefits Begin

LTD benefits begin if you satisfy all of the following requirements:

- ➤ You become disabled while your coverage is in effect
- ➤ You remain disabled throughout and beyond the elimination period
- ➤ You are under the regular care of a physician
- ➤ You submit satisfactory proof of your disability

LTD benefits generally start if you are still disabled when your STD benefits end. (You cannot receive absence pay and LTD benefits at the same time.)

How Benefits Are Paid

You generally receive your LTD benefit check from the insurance company at the end of each month. The amount you receive may be subject to income tax withholding.

How Long Benefits Continue

If you become disabled before age 63 and remain disabled, your LTD benefits continue until you reach normal Social Security retirement age, or for 42 consecutive months (whichever is greater).

If You Become Disabled at or After Age 63

If you become disabled at or after age 63, you receive benefits until you recover, or for the period of time shown in the chart below (whichever is earlier).

Age When Disability Begins	Maximum Benefit Period
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

The maximum LTD benefit period is based on your age when you become disabled – not the age you begin receiving LTD benefits.

For example, suppose you become disabled at age 63 and you receive STD benefits for 26 weeks. Then, LTD benefits start two months after you turn age 64. Because your disability started at age 63, you are eligible for up to 36 months of LTD payments, or until your disability ends (whichever occurs first).

When Benefits End

LTD benefits end on the day (whichever occurs first):

- You are no longer disabled (as defined on page 111)
- You fail to furnish proof of loss when requested
- You are no longer under the regular care of a physician, or you refuse to submit to an examination by a physician
- You earn 80% or more of your indexed pre-disability earnings if you are receiving benefits for being disabled from your own occupation, or 60% or more of such earnings if you are receiving benefits for being disabled from any occupation (as defined on page 111)
- No further benefits are payable under the plan
- The maximum benefit period ends (as shown on page 111 and above)
- You refuse to participate in a rehabilitation plan or you refuse to cooperate with or try any:
  - Modifications made to your work site or job process to accommodate your identified limitation so that you can perform the essential duties of your own occupation
  - Adaptive equipment or devices designed to accommodate your identified limitation so that you can perform the essential duties of your own occupation
  - Modifications made to your work site or job process to accommodate your identified limitation so that you can perform the essential duties of any occupation (if you are receiving benefits for being disabled from any occupation)
  - Adaptive equipment or devices designed to accommodate your identified limitation so that you can perform the essential duties of any occupation (if you are receiving benefits for being disabled from any occupation)
- You refuse to receive recommended treatment that is acknowledged by a licensed physician to cure, correct, or limit your disabling condition
- You die
- You fail to cooperate with the insurance company in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable on the actual benefit amount due

If You Die

If you die while you are receiving LTD benefits, your family receives a family survivor benefit. The family survivor benefit equals three times your last monthly LTD benefit (up to $25,000).

Your surviving family members receive this benefit in a single lump-sum payout. For this benefit, your survivor is your lawful spouse if living; otherwise, your children under age 25. If there are no eligible survivors, this benefit is paid to your estate.

Limitations

Certain limitations apply to your disability coverage.

Limitations to Mental/Nervous Conditions and Drug/Alcohol Abuse

Disability benefits are paid on a limited basis for any disabilities caused by, or contributed to by, any one or more of the following conditions. Once 12 monthly benefit payments have been made during your lifetime, no further benefits will be payable for any of the following conditions:

- Alcoholism
- Anxiety disorders
- Delusional (paranoid) disorders
- Depressive disorders
- Drug addiction or abuse
- Eating disorders
- Mental illness
- Somatoform disorders (psychosomatic illness)

If before reaching your lifetime maximum benefit, you are confined in a hospital for more than 14 consecutive days, that period of confinement will not count against your lifetime limit. The confinement must be for the appropriate care of any of the conditions listed above.

Mental Illness

Any psychological, behavioral or emotional disorder or ailment of the mind. It includes physical manifestations of psychological, behavioral or emotional disorders, but does not include demonstrable structural brain damage. The plan limits benefits associated with one of the above conditions to 12 months per lifetime (provided you are being treated for the condition on an outpatient basis). This limit does not apply if you are hospitalized or confined for the condition in a licensed medical care facility.

Medical Care

Medical care includes medical exams, tests, attendance or observation, use of drugs, medicines, supplies or equipment.

Pre-Existing Conditions

A pre-existing condition is any accidental bodily injury, sickness, mental illness, pregnancy or substance abuse condition (or any symptom related to these) for which you receive medical care during the 90-day period before your disability coverage begins.

The plan does not pay LTD benefits for any disability that results from a pre-existing condition, unless your disability begins at least 365 consecutive days after your coverage effective date.

Situations Affecting Your LTD Benefits

Certain situations could affect your LTD benefits. For additional information on how long this coverage continues, see page 17 of the ***Participation*** section.

Recurrent Disabilities

If you attempt to return to work during the 180-day elimination period but again become disabled, you must meet a new elimination period if you return to work for more than 30 days. Any day you work does not count toward your new elimination period.

A separate period of disability will be considered continuous:

- If it results from the same or related causes as a prior disability for which benefits were payable and
- If, after receiving disability benefits, you return to your work in your regular occupation for less than six months and
- If you earn less than the percentage of pre-indexed pre-disability earnings that would still qualify you to meet the definition of disability during at least one month

Indexed Pre-Disability Earnings

Indexed pre-disability earnings include your base pay (see page 112) as of the date your disability begins, with an adjustment on each anniversary of the start of your LTD benefits. The annual adjustment is the less of 10% or the current annual percentage increase in the Consumer Price Index (CPI).

Any period of later disability, regardless of cause, that begins when you are eligible for coverage under another group disability plan provided by WM will not be considered a continuous period disability.

For any separate period of disability which is not considered continuous, you must satisfy a new elimination period.

If You Return to Work (Work Incentive Benefit)

If you are disabled but can return to work for wage or profit, you may still receive LTD benefits. The benefit you receive while you are working is called a “work incentive benefit.” A special calculation applies.

You can receive the work incentive benefit in addition to your LTD benefit as long as the total of the two monthly earnings do not exceed 100% of your indexed pre-disability earnings. As a result, you have the opportunity to earn up to 100% of your indexed pre-disability earnings. If you were to only receive the LTD benefit, the benefit would only replace 60% of your base pay.

From time to time the insurance company reviews the status of your condition. As a result, you may have to provide satisfactory proof of your earnings as well as your continued disability.

As with your other plan benefits, the work incentive benefit ends when you are no longer disabled, when you reach the maximum benefit period or you die.

Rehabilitation

You and WM may work together to plan, adapt, and put into place various work-related options to meet your return-to-work needs. A rehabilitation program may include:

- Vocational training
- Vocational testing
- Alternative treatment plans
- Workplace modifications
- Job placement

If the insurance company determines that you are a suitable candidate for rehabilitation, you may be required to participate in a rehabilitation plan and assessment at their expense. The insurance company has the sole discretion to approve your participation in the rehabilitation plan. The insurance company will work with you, WM and your doctor, and others as appropriate, to perform the assessment, develop a plan and discuss return to work possibilities.

The rehabilitation plan may allow for payment of your medical expense, education expense, moving expense, accommodation expense or family care expense while you are participating in the program. If you fail to cooperate fully in all phases of the rehabilitation plan and assessment without good cause, no disability benefits will be paid and insurance will end.

If you are working under a rehabilitation program, the plan deducts the cost of any day care services you may incur from the earnings received from such a program. The maximum monthly deduction is $350 for the first 12 months of rehabilitative employment and $175 thereafter (up to a $2,500 credit per year).

Conversion Privileges

If your insurance ends because employment with WM ends, or you are laid off or on an uninsured leave of absence, you may be eligible for conversion insurance.

To be eligible for conversion insurance, you must have LTD coverage and be actively at work for at least 12 straight months. You must apply for conversion within 62 days after your insurance ends. If you apply within 31 days of the date your coverage under the LTD benefit ends, your conversion insurance will be effective as of the date your coverage under the LTD benefit ends. However, if you apply for conversion more than 31 days after insurance under the group policy ends, you will be required to provide satisfactory evidence of insurability at your own expense. Conversion will be effective on the date the insurance company agrees in writing to insure you.

The benefits of the conversion plan will be those benefits offered at the time you apply. The premium is based on the rates in effect for conversion plans at that time.

Conversion insurance is not available if any of the following conditions apply:

- You are retired or age 70 or older
- You are not in active service because of disability
- The group policy is canceled for any reason
- You are no longer in a class of eligible employees, but are still employed by WM

Disabilities Not Eligible for STD or LTD Benefits

You do not receive STD or LTD benefits for disabilities that are caused by or result from:

- An intentional self-inflicted injury or illness
- A war or any act of war, whether declared or undeclared
- Injuries or illnesses arising out of your work for another employer, including injuries or illnesses covered under any workers' compensation or any occupational disease law
- A commission of or attempt to commit a felony
- An illegal occupation
- Active participation in a riot
- Incarceration in a penal or correctional institution
- Injuries or illnesses arising out of your work at WM, including injuries or illnesses covered under any workers' compensation or any occupational disease law claims (STD only)
- Cosmetic surgery or any surgical procedure that is not medically necessary (STD only)
- Transplant donor surgery – surgery due to donating an organ to someone else (STD only)

You do not receive STD or LTD benefits for disabilities that occur while you are on a leave of absence from WM.

Applying for STD and LTD Benefits

You need to apply to receive STD benefits. If you receive STD benefits from WM, the insurance company will automatically initiate the claims process for LTD benefits (for non-statutory states only).

To Report a Claim

To report a disability claim, call TOPS at 877-216-8677.

You need to provide the following information:

- Your name, address, phone number, birth date, date of hire, and Social Security number and the address, phone number and supervisor's name for your work location
- The date and cause of your disability, and your anticipated return-to-work date
- Your doctor's name, address and phone number

After you call, a representative contacts you to discuss the claims process. You then receive a claim form for your signature, as well as a form authorizing your physician to release your medical information.

Deadline for Filing a Claim

You have up to one year from the date your disability begins to file your claim for payment. Claims filed or received after one year are not eligible for benefits.

Filing a Claim for LTD Benefits

Please refer to page 22 of the ***Participation*** section for more information on eligibility and enrollment claims.

The claims processes described in the ***Participation*** section and below do not apply to the STD program. If your claim for STD benefits is denied, you may appeal the decision to the Administrative Committee of the Waste Management Employee Benefit Plans by sending a written request for review. The Committee will review your claim for STD benefits and notify you in writing of its decision and the reason for it.

The Administrative Committee of the Waste Management Employee Benefits Plan has the initial authority to decide whether an individual is eligible to participate in the plan. The insurance company has the authority to decide whether an individual is disabled under the plan and the amount of benefits that are payable to such an individual. When LTD payments are made or denied, you will receive a notice explaining how payments have been calculated or why benefits have been denied. This notice will generally be given within 45 days unless the insurance company notifies you in writing that an extension (not to exceed 60 days) is needed.

If you believe that a payment calculation or denial is wrong, you may request a full review by the insurance company within 180 days after you receive the notice. In connection with your appeal, you or your representative can review relevant documents and submit issues and comments in writing. See page 22 for a description of the relevant documents you can request. If you want to appeal a decision on disability benefits, send your appeal to the insurance company listed in the ***Administrative Information*** section of this handbook.

The insurance company will review your appeal. Someone other than the person who made the first decision on your claim must make this review. The insurance company must disclose the identity of medical or vocational experts whom it consults in connection with your claim. If the benefit determination is based on a medical judgment, the insurance company must consult with a health care professional that has the appropriate training and experience in the field of medicine involved. After the insurance company makes a decision concerning your appeal, it will notify you of its findings and decision in writing within 45 days (unless special circumstances require an extension not to exceed an additional 60 days) after it receives your appeal. The notice given to you concerning the insurance company's decision on either your initial claim or your appeal will include:

- The specific reason or reasons for the decision
- The specific plan provisions upon which the benefit decision is based
- A description of any additional material or information that is necessary for you to complete your claim and an explanation of why such material or information is necessary
- If an internal rule, guideline, protocol or similar criteria was relied on in making the decision, either a copy of that document, or a statement that such a document was relied upon and that a copy will be furnished (free of charge) upon request
- If the decision is based on a medical limit (for example, a decision that the proposed service is not
- medically necessary or that it is experimental), either an explanation of the scientific or clinical
- judgment for the decision (applying the plan's terms to your medical circumstances), or a statement that such an explanation will be provided free of charge upon request
- For an initial claim, a description of the appeal procedures

State-Specific Information

Certain states require specific provisions for disability insurance. These special LTD provisions under the plan are designed to conform to individual state laws. The following chart lists the state-specific provisions.

Please note: If you live in California, Hawaii, New Jersey, Puerto Rico or Rhode Island, you have your own state disability plan. You should contact your state disability office for information on how to file a claim. Phone numbers and addresses are in your local phone book.

Arkansas	For claims that you cannot resolve through the carrier, please contact: Arkansas Insurance Department Consumer Services Division 1200 West Third Street Little Rock, AR 72201-1904 Telephone: 800-852-5494 The minimum monthly benefit is $50.
California	You may be able to continue your coverage for up to 12 weeks during any 12-month period if you are absent from active full-time work due to a family care or medical leave under the California Family Care and Medical Leave Act's provisions. Contact your Human Resources representative for further information on your rights to continue coverage.
Massachusetts	If your coverage ends because you terminate employment or you are no longer eligible, your coverage automatically continues for 31 days following the day your coverage ends, or until you become eligible for similar benefits under another group plan (whichever occurs first). If your coverage ends due to a plant closing or a partial closing, you may be able to continue your coverage. To do so, you must make your election in writing and pay the required premium. Coverage ends on the earliest of the following: - 90 days from the day you were no longer eligible as an active full-time employee - The day you become eligible for similar benefits under another group plan - The last day of the period for which you make your required premium - The day the group policy terminates - The day the Company no longer participates in the policy (if applicable)
Minnesota	Disability benefits are limited if you are disabled because of: - A mental illness that results from any cause - Any condition that may result from a mental illness - Alcoholism - The non-medical use of narcotics, sedatives, stimulants, hallucinogens or any other such substance The plan pays benefits provided you are confined in a hospital or other licensed medical care facility. If you are not so confined, the plan pays benefits for up to 12 months per lifetime for all such disabilities.

	You must provide written proof of loss to the carrier within 90 days of the start of the period for which the carrier owes payment. After that, the carrier may require further written proof that you are still disabled. If you do not provide proof by the time it is due, your claim is not affected if it was not possible to give proof within the required time and you give proof as soon as possible. The carrier has the right to require the following as part of the proof of loss: - A signed statement that identifies all of your other sources of disability income - Satisfactory proof that you or your dependents duly applied for all other available sources of disability income benefits
New Hampshire	If you have questions about a claim, call the carrier at 800-238-2125. When you call, be sure to provide: - The policy number (STD-SHD985022 / LTD-LK980024) - The name of the policyholder (WM)
New York	The plan does not pay benefits for any disability that is due to, contributed to by, or results from a preexisting condition (unless the disability starts once you have been covered under the plan for 365 consecutive days). However, if you were covered under a group or blanket disability insurance plan or an employer-provided disability benefit arrangement within 60 days of your coverage effective date under this plan, any treatment-free-period requirements or period-of-coverage requirements that you partially satisfied under previous coverage are credited toward the 365-day period under this plan. If you were previously covered under another plan within 60 days before your coverage effective date under this plan, the preexisting condition limitation under this plan ends on the day (whichever occurs first): - Your coverage under your previous plan took effect (provided your previous cover age did not limit coverage for your disability under any preexisting condition restriction) - If your previous coverage limited coverage for your disability under a pre-existing condition restriction, the day the restriction ended (had your previous coverage remained in force) - You return to work as an active full-time employee before this plan's coverage effective date and you have a recurrence of the same disability within six months of your return to work, and no benefits are available for the recurrence of your disability under the prior plan - The elimination period under this plan is waived if you received monthly LTD benefits for a disability under a previous coverage Your previous coverage can be any employer-provided disability benefit arrangement or group or blanket long-term disability insurance plan carried by WM on the day before your coverage effective date under this plan.
North Carolina	Your "other sources of disability income" also includes any retirement benefits under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or a similar plan or act that you or your family receive because of your retirement, unless you were receiving them before becoming disabled. You no longer need to be under the regular care of a physician to be eligible for benefits if, in the opinion of a qualified medical professional, further medical care and treatment is of no benefit to you.

	You must provide written proof of loss to the carrier within 90 days of the period for which the carrier owes payment. After that, the carrier may require you to provide further written proof of your disability. If you do not, your claim is not affected provided you were not able to provide proof within the required time, and you provide the proof as soon as possible (but no later than one year after it is due – unless you are not legally competent). The carrier has the right to require as part of proof of loss: - A signed statement that identifies all of your other sources of disability income and - Satisfactory proof that you and your dependents have duly applied for all other available sources of disability income The carrier reserves the right to determine if your proof of loss is satisfactory. You are not required to claim any retirement benefits that you may only get on a reduced basis. You must give the carrier written notice of a claim within 30 days after your disability begins. If you cannot provide such notice within this time period, you must provide it as soon as possible. Your notice should include your name, address, and the group policy number (STD-SHD985022 / LTD-LK980024). Send your notice to WM or to the carrier.
Oklahoma	WARNING: A person is guilty of insurance fraud if s/he: - Knowingly and with intent to injure, defraud, or deceive, makes a claim for insurance proceeds - Provides any false, incomplete, or misleading information when making a claim for insurance proceeds
Pennsylvania	“No fault” automobile insurance is not an “other source of disability income” in the Commonwealth of Pennsylvania.
Vermont	If you have questions regarding a claim, call the carrier at 800-238-2125. When you call, be sure to provide: - The policy number (STD-SHD985022 / LTD-LK980024) - The name of the policyholder (WM)
Wisconsin	The carrier is entitled to any rights you may have against a third party and may at its option bring legal action to recover such payments made in connection with a disability if you: - Suffer a disability because of an act or omission of a third party - Become entitled to and receive benefits under this policy to compensate for lost wages - Do not initiate legal action for the recovery of such benefits from the third party in a reasonable period of time The carrier may exercise such right only if you have been, or will be, fully compensated for your lost wages.

Flexible Spending Accounts

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The WM benefit plan offers you a way to pay certain health and dependent day care expenses with pre-tax dollars: the Flexible Spending Accounts. As you read about Flexible Spending Accounts (FSAs), keep the following in mind:

- Each year at annual enrollment, you decide whether or not to use the accounts and how much to contribute during the upcoming year
- The two accounts – the Health Care Account and the Dependent Day Care Account – are designed to help you pay qualified health and dependent day care expenses on a pre-tax basis. You can set aside money in one, both, or neither account(s)
- Because your contributions are not taxable, you save by paying less in income tax. You may want to consider whether a spending account could help you pay less in taxes each year
- The Health Care Account is designed to help you pay for certain medical, dental, vision, and hearing expenses not covered under the WM medical plan or any other Company-sponsored plan. See page 131 for a list of eligible expenses
- The Dependent Day Care Account is designed to help you pay for eligible dependent day care expenses you incur while you and your spouse (if you are married) are at work. See page 133 for a list of eligible expenses
- You fund your accounts through pre-tax paycheck deductions. These funds remain in your account(s) until after your claim is filed. After filing, you are reimbursed with tax-free dollars from the appropriate account
- If at the end of the 14½ month claims period (January 1 through March 15 of the following year) the funds remaining in either account exceed the total amount of your claims, you forfeit the excess amount as required by IRS regulations
- Remember, your Health Care Account is different than an HSA. See page 36 for more information regarding the HSA. If you participate in the HSA, you may only use your Health Care Account as a Limited-Use FSA

If You Have Questions

If you have questions about Flexible Spending Accounts, log on to *Your Spending Accounts (YSA)* through the mywmtotalrewards.com website or call the Benefits Center at 800-964-3373.

A Snapshot of Your Flexible Spending Accounts

We are all looking for ways to save money. Flexible Spending Accounts can be one of them. By using pre-tax dollars to pay certain eligible health and dependent day care expenses, you may save on taxes each year. The chart below is a snapshot of the Health Care and Dependent Day Care Accounts.

	Type of Account	
	Health Care	**Dependent Day Care**
Eligible Expenses	Qualified medical, dental, vision, and hearing expenses not covered under the WM medical, vision or dental plans (for example, deductibles, copayments, coinsurance); over-the-counter drugs (only if prescribed in writing by a physician)	Eligible dependent day care expenses you incur while you and your spouse are at work
Qualified Dependents	Your spouse and your children as defined on pages 6 and 7 in the ***Participation*** section of this handbook*	A child* under age 13 (or a handicapped child of any age) whom you claim as a dependent on your income tax return; also, your parent whom you claim as a dependent on your income tax return, or your disabled spouse
Minimum Annual Contribution	$120 per year	$520 per year
Maximum Annual Contribution	$2,500 per year (per family) (as adjusted for inflation in later years)	$5,000 per year (per family)

*Generally, employees cannot submit expenses for domestic partners and domestic partner's children.

How Your Flexible Spending Accounts Work

Your Flexible Spending Accounts work with you so that you can reimburse yourself for certain health and dependent day care-related expenses on a pre-tax basis.

What You Need to Do

To make the spending accounts work for you:

- ➤ Estimate your expenses – Log on to mywmtotalrewards.com and use the *Your Spending Account* estimator tools
- ➤ Determine how much to contribute – This amount is deducted (before taxes) in equal amounts from your paycheck. These funds are deposited into the appropriate spending account and remain there until you file a claim for reimbursement
- ➤ Incur expenses – Log on to mywmtotalrewards.com to obtain a list of eligible expenses. Any expenses incurred before your enrollment do not qualify for reimbursement
- ➤ Receive auto-reimbursement or file a claim – See ***Applying for Reimbursement*** on page 134 for instructions on how to get reimbursement

Under Federal law, if you participate in the Dependent Day Care Account and your spouse participates in a similar account through his or her own employer, your combined annual contributions to the account may not exceed $5,000. This limit applies regardless of the number of dependents receiving care. If you and your spouse file separate income tax returns, the most each of you may contribute is $2,500. In addition, if you are married, your Dependent Day Care Account contributions may not exceed the annual income of the lower-paid spouse.

In general, you may not participate in the Dependent Day Care Account if your spouse does not work outside the home. There are two exceptions: if your spouse does not work outside the home and is physically or mentally unable to care for himself or herself, or if your spouse is a full-time student. In either of these cases, for purposes of calculating the contribution limit, the IRS considers your spouse's earned income to be:

- $250 a month ($3,000 a year) if you have one dependent
- $500 a month ($6,000 a year) if you have two or more dependents

If you participate, it is your responsibility (not WM's) to comply with the federal limits applicable to you.

Two Accounts Treated Separately

One additional consideration when estimating your expenses: the Health Care and Dependent Day Care Accounts are separate. This means you cannot use money deposited in your Health Care Account to pay dependent day care expenses, and vice versa.

Changing Your Contributions

In general, you cannot change the amount of your contributions during the year unless you have a change of status that affects your participation. See page 11 of the ***Participation*** section for more details.

Forfeiture of Contributions

In general, your Flexible Spending Accounts will reimburse eligible expenses incurred during the year and through March 15th of the following year. (If you are no longer an active employee and contributing to the Flexible Spending Accounts, you may be able to continue participating in the Health Care Account through COBRA.)

If you do not use the entire balance in your account(s) by the following March 15th, the IRS requires you to forfeit the remaining funds. This money is not available for future expenses or a refund.
For both the Flexible Spending Accounts, you have until April 30 to submit claims for expenses incurred between January 1st of the previous year and March 15th of the current year.

A Word About Taxes

Your Flexible Spending Account contributions reduce your taxable income – meaning you pay less in taxes. Your contributions, as well as the money reimbursed to you, are not subject to:

- Federal income taxes
- Social Security (FICA) taxes
- In most cases, state and local income taxes

Rules vary, and state and local tax laws are subject to frequent change.

An Example of How Your Flexible Spending Accounts Can Help You Save

This chart illustrates the potential tax savings when using Your Flexible Spending Accounts:

If You Contribute:	Your Tax Savings Could Be:
$500	$133
$1,000	$266
$1,500	$340
$2,000	$453
$3,000	$679
$4,000	$906

These tax savings are based on the minimum income tax rate of 15% and the Social Security (FICA) rate of 7.65%. If your income tax rate is higher, and/or you also pay state and local taxes, you will save even more in taxes by using Your Flexible Spending Accounts. As you can see, participating in these accounts can make your spendable pay go further. Consider this: by using Your Flexible Spending Accounts to pay for $4,000 of eligible expenses, you could save at least $906 in taxes for the year. In other words, you "spend" $3,094 to pay for $4,000 worth of eligible expenses.

Effect of Pre-Tax Contributions on Your Other Benefits

Pre-tax contributions reduce the Social Security taxes you pay. Therefore, the eventual Social Security benefit you may be eligible to receive may be reduced. Because Social Security benefits are based on your career earnings, in most cases, this reduction will be minimal (if anything). For more information, contact your local Social Security Administration office.

Alternate Tax-Saving Approaches

You may be eligible to take a deduction or tax credit on your income tax return for eligible health and/or dependent day care expenses.

Health Care Account vs. the Income Tax Deduction

Under current tax law, most expenses reimbursed through your Health Care Account are normally deductible on your federal income tax return if they exceed 7.5% of your adjusted gross income. When you use your Health Care Account to reimburse these expenses, you give up the opportunity to take a tax deduction for these same items. So, when you consider whether to enroll in the Health Care Account, decide whether you want to take the deduction on your income tax return, or reimburse the expenses through the Health Care Account. Generally, if you do not itemize deductions, or if your health care expenses are less than 7.5% of your adjusted gross income, it may be better to use the Health Care Account.

Dependent Day Care Account vs. the Income Tax Credit

The Dependent Day Care Account is not for everyone. In general, if your family's total adjusted gross income for federal income tax purposes is:

- More than $40,000, the Dependent Day Care Account may offer greater advantages
- Less than $40,000, the tax credit may be more advantageous, depending on your marital status, income level, number of dependents receiving care, and other factors

Depending on your income level, you can take a tax credit from 20% or 35% of your annual dependent day care expenses on your federal income tax return. These expenses are limited to $3,000 for a single dependent and $6,000 for two or more dependents receiving care.

You can't use the Dependent Day Care Account and the tax credit for the same expenses. The IRS reduces your available tax credit by $1 for each $1 of reimbursement you receive from your Dependent Day Care Account.

However, there are some exceptions to this rule. To help you determine which method is better for you, you should consult a tax advisor.

Comparison Snapshot

A brief comparison of the tax alternatives:

Dependent Day Care Account	vs.	Income Tax Credit
Immediate savings using pre-tax dollars. No taxes paid up to $5,000 of eligible dependent day care expenses for one or more eligible dependents.		Deferred savings until you file taxes. Tax credit of 20%-35% on maximum of $3,000 of expenses for one dependent or $6,000 for two or more.
Forfeit any funds that remain in your account at the end of the year.		N/A
Reduces federal, Social Security, and many state and local taxes.		Does not reduce Social Security, but reduces federal and many state and local taxes.

Regarding the Tax-Saving Approaches

It is important to note that any tax saving that may result from your participation in the spending accounts depends on your personal situation and income level. The tax information in this handbook is only general information. Because tax law is complicated and subject to frequent change, you should talk with a qualified tax advisor before you decide whether to use the spending accounts or to take a tax deduction.

By law, WM cannot offer you tax advice or advise you on spending account-related decisions. This law is designed to protect you by ensuring that you always get the most up-to-date advice, and that advice is only available from a qualified tax advisor.

The Health Care Account

You can use the Health Care Account to reimburse your and your eligible dependents' health-related charges that are:

- Not covered under any medical, dental or vision plans
- Incurred for medical care, including the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body
- Incurred during the plan year in which you participate in the Health Care Account (or during the January to March 15th extension period following that plan year)

Eligible Dependents

In addition to yourself, you can use the Health Care Account to pay out-of-pocket expenses for your eligible dependents, as defined on pages 6 and 7 in the ***Participation*** section of this handbook. Eligible dependents include your adult child through age 26. Generally, you cannot submit expenses for domestic partners and domestic partner's children.

Eligible Expenses

The following are examples of eligible expenses the Health Care Account reimburses. There also are other expenses that qualify for reimbursement. To view a complete list, visit mywmtotalrewards.com. Remember, if you have an HSA, your Health Care Flexible Spending Account can only be used as a Limited-Use FSA.

- Eligible over-the-counter drugs (prescription required) and supplies used to treat an illness or injury as defined by the IRS
- Acupuncture
- Alcohol or drug dependency treatment and treatment centers
- Contact lens solution
- Dental expenses (excluding cosmetic dental expenses, such as teeth whitening) if you elect no coverage under the dental plan. It may also be used to pay for dental services that are not covered or are over the annual dollar limits
- Charges that exceed reasonable and customary limits
- Hearing care expenses, including those for examinations and hearing aids
- Medical and dental deductibles, coinsurance and copayments for office visits and prescriptions
- Vision care expenses such as examinations, treatments, eyeglasses and contact lens expenses not covered by a benefit plan
- Weight loss treatment (with the exception of food costs) associated with a diagnosed disease or ailment such as obesity or hypertension

Expenses Not Covered

The following are examples of expenses that are not eligible for reimbursement from the Health Care Account.

- Over-the-counter drugs that are not prescribed by a physician
- Over-the-counter drugs and supplies used to promote general health (e.g., vitamins, herbs)
- Cosmetic treatment or drugs, unless prescribed to treat a congenital defect or accident reconstruction, including:
  - Hair loss treatments or transplants
  - Face lifts
  - Piercings
  - Teeth whitening

- ➤ Health club memberships or exercise classes to promote general health
- ➤ Household help (even if recommended by your doctor because you are unable to do housework)
- ➤ Individual health or dental insurance premiums
- ➤ Marriage or family counseling
- ➤ Sales tax on any qualified expense
- ➤ Weight loss programs not associated with a diagnosed disease or ailment or dietary supplements taken to promote general health (e.g., vitamins, herbs)

The eligible and ineligible expenses listed here are only examples. Other expenses may be eligible for reimbursement. To learn more, see IRS Publication 502, log on to the mywmtotalrewards.com website or call the Benefits Center at 800-964-3373.

Impact of a Health Savings Account

If you have an HSA, you may only use your Health Care Account to reimburse eligible dental and vision expenses. Refer to IRS Publication 502 for a description of these expenses.

Amounts you contribute to your Health Care Account while you participate in the HSA can only be used for dental and vision expenses. So, if you participate in an HSA in one year; but not in the following year, you cannot submit other qualified medical expenses incurred during the grace period for reimbursement from any leftover money in your Health Care Account.

The Dependent Day Care Account

You can use the Dependent Day Care Account to pay for many types of dependent day care expenses. However, to qualify as an eligible expense, all of the following must be true:

- ➤ Care for your dependent(s) must be necessary for you and your spouse to work, look for work, or go to school full time. In other words, expenses are not eligible if they are for services provided while you are out for the evening socially or on vacation
- ➤ The expenses must be incurred during the plan year in which you participate (or during the January to March 15th grace period following that plan year)
- ➤ If the care is provided by a day care facility that cares for six or more individuals at the same time, the facility must be licensed
- ➤ Your care provider is anyone other than a person whom you claim as a dependent on your federal income tax return (a son or daughter who provides care must be at least age 19). In addition, you must provide your caregiver's name, address, and Social Security number or taxpayer identification number when you file for reimbursement. You also must provide this information on your federal income tax return, unless your caregiver is a church or other religious organization

Eligible Dependents

An eligible dependent is a child younger than age 13 whom you claim as a dependent on your federal income tax return. An eligible dependent can also be an older dependent who:

- ➤ Depends on you for at least half of his or her support
- ➤ Regularly spends at least eight hours a day in your household
- ➤ Is physically or mentally unable to care for himself or herself

Your dependent may be a disabled spouse, an elderly parent, or any other relative or dependent, as long as that person meets all of the above requirements.

Eligible Expenses

The Dependent Day Care Account can be used to pay for IRS-specified dependent day care expenses you incur so that you may work or attend school full time. It is important to contribute money only for dependent day care expenses you know you will have during the upcoming year. Do not forget to subtract the times during which your dependent will not receive care, such as vacation or sick time.

The following are examples of the types of expenses for which you can use the Dependent Day Care Account:

- Dependent care provided in your home, including care provided by a babysitter or housekeeper. The provider may be a relative (provided it is not your child under age 19, your spouse, or any other person whom you claim as a dependent)
- Dependent care provided outside your home, including care provided in a neighbor's home or in an approved day care center, provided your dependent regularly spends at least eight hours a day in your home. For example, day care centers for children and disabled adults qualify, but 24 hour nursing care facilities do not. Also, facilities that care for six or more individuals must comply with all federal, state, and local regulations governing day care centers
- Household services, such as housekeeping or maid services, provided they are necessary to run your home for the wellbeing and protection of your eligible dependent
- Before- and after-school programs for children under age 13
- Day camp services for children under age 13, but not overnight camp

Expenses Not Covered

Some expenses do not qualify for reimbursement through the Dependent Day Care Account, including:

- Medical expenses for your dependents (these are reimbursed through the Health Care Account)
- Dependent care expenses incurred before your Flexible Spending Account participation begins
- Expenses you claim as an after-tax dependent day care tax credit on your federal income tax return, or expenses paid by any similar reimbursement plan
- Expenses to attend kindergarten grade or beyond
- Care provided by a round-the-clock nursing home
- Services provided by your spouse, your child under age 19, or someone you or your spouse claim as a dependent on your tax return
- Payments to a housekeeper while you are home from work because of illness
- Child or dependent day care provided while:
  - You are at work and your spouse is doing volunteer work (or vice versa), even if a nominal fee is paid
  - You and your spouse are doing volunteer work (even if a nominal fee is paid)
  - You or your spouse is not working (such as weekend or evening babysitting fees)
- Transportation expenses to and from the care site
- Expenses for overnight camp
- Expenses for food, clothing and entertainment of a qualified dependent, unless charges are incidental and cannot be separated easily from the overall dependent day care cost

The eligible and ineligible expenses listed here are only examples. Other expenses may be eligible for reimbursement. To learn more, log on to the mywmtotalrewards.com website or call the Benefits Center at 800-964-3373.

Applying for Reimbursement

Reimbursement from Flexible Spending Accounts is available only after the service for which you are seeking reimbursement is performed and you receive reimbursement from all other sources. There are several ways you can be reimbursed:

Auto Reimbursement: For medical (Cigna), prescription drug (Catamaran), dental (Delta Dental) and vision (VSP) expenses, reimbursements will be automatically generated based on the information submitted to the claim administrator by your provider; you do not need to complete a claim form or file any paperwork. If you do not wish to have your claims automatically reimbursed, you can contact the Benefit Center and ask that auto-reimbursement be discontinued.

Online: You can also submit a completed form online through the mywmtotalrewards.com website.

If you complete an online or paper form, you must send your signed form, along with all supporting documentation (such as an explanation of benefits or itemized receipts) to:

By fax: 888-211-9900

By mail: Your Spending Account
P.O. Box 785040
Orlando, FL 32878-5040

Paper: You can obtain a paper claim form by calling the Benefits Center at 800-964-3373.

Due to the tax advantages available through the Health Care Account and the Dependent Day Care Account, there are a few important IRS rules to keep in mind when filing your claim:

- You must submit supporting documents from a third party in support of your claim. These documents must describe the service or product you received, the date of the service or sale, and the amount of the expense. The following will not be accepted: receipts that do not itemize each service or item you received, verbal information from you, handwritten information from you, cancelled checks, or online bank statements. Any claim for services or products received outside the US must include a translation of the supporting documents.
- You can only be reimbursed from Your Flexible Spending Account for services already received, regardless of when you pay for them. For example, if you pay for daycare services for the month at the beginning of the month, you should wait until the end of the month before submitting those services for reimbursement after the services have been performed. If you submit an itemized receipt half-way through the month, you can only be reimbursed for half a month of daycare expenses.
- Any receipt you submit for day care services must include the period covered by the receipt, the daily rate and/or the number of days covered by the receipt.

If you do not fax or mail the completed form with supporting documentation, your claim will not be processed and you will not be reimbursed.

Reimbursements Direct Deposited

You can elect to have Your Flexible Spending Accounts reimbursements directly deposited into your checking or savings account. Visit the mywmtotalrewards.com website to set up direct deposit.
If you have any claim questions, please call the Benefits Center at 800-964-3373.

Health Care Reimbursements

Expenses eligible for reimbursement from other medical, dental or vision plans must be submitted to your plan coverage first. After a payment determination is made, you can submit the un-reimbursed expense for reimbursement to your Health Care Account.

The full annual amount you elect to contribute to your account (less any previous reimbursements) is available for reimbursement of eligible health-related expenses, regardless of the amount contributed to date. Contributions continue to be deducted from your pay to cover any claims already fully reimbursed from the Health Care Account.

Dependent Day Care Reimbursements

For Dependent Day Care Account claims, only your current account balance is available to reimburse claims. If the dependent day care services exceed your account balance, you will receive a partial reimbursement. You will receive the unreimbursed portion of the claim as you make additional contributions to your Dependent Day Care Account.

Claim Filing Deadline

You may file claims at any time after you incur the expense. For both the Flexible Spending Accounts, you have until April 30 to submit claims for expenses incurred between January 1st of the previous year and March 15th of the current year.

Remember, IRS regulations require that you forfeit any money that remains in Your Flexible Spending Accounts after the applicable deadline.

Filing a Health Care Account Claim

These procedures apply to Health Care Account claims. The Administrative Committee of the Waste Management Employee Benefits Plan has the authority to decide whether an individual is eligible to participate in the plan. A claim administrator has the authority to decide the level of benefits that are available to an individual. Please refer to page 22 of the ***Participation*** section for more information on eligibility and enrollment claims.

Initial Claim Decision

When a claim is received for a Health Care Account benefit, the claim administrator must decide whether (or at what level) the Health Care Account benefit is covered under the plan. When the Health Care Account benefit is provided or denied, you will receive a notice explaining how the coverage level was calculated or why benefits have been denied. How fast this notice must be given to you depends on whether the claim is an urgent care claim, a pre-service claim or a post-service claim. The deadline for this notice is no later than:

- For an urgent care claim, 72 hours after the claim is received
- For a pre-service claim, 15 days after the claim is received
- For a post-service claim, 30 days after the claim is received

The following rules apply if your claim is an urgent care claim or a pre-service claim:

- You will be notified of the decision whether or not it is adverse
- You can be notified of an initial decision orally, if a written or electronic notice is provided no more than three days after the oral notice

Failure to Follow Urgent Care or Pre-Service Claims Procedures

If you fail to follow the procedures for filing an urgent care claim or a pre-service claim, you will be notified of the failure and the proper procedure to be followed. This notice must be provided to you no later than 24 hours after the failure for urgent care claims or five days after the failure for pre-service claims. This notice may be oral unless you (or your representative) request a written notice. This notice is triggered when:

- You (or your representative) make a communication that is received by a person or organization unit customarily responsible for handling benefit matters and
- The communication names a specific participant or covered dependent, a specific medical condition and a specific treatment, service or product for which approval is requested

Notice of Incomplete Urgent Care Claim

If you (or your representative) properly submit an urgent care claim that is missing necessary information, you will receive a notice. This notice will tell you the specific information needed to complete the claim. The notice will be given to you no later than 24 hours after receiving the claim. You must be given a reasonable time to provide the information but not less than 48 hours. You will be notified of the decision concerning your urgent care claim as soon as possible but no later than 48 hours after the earlier of:

- When the plan receives the requested information or
- The end of the period you were given to provide the information

Concurrent Care Claim

At times, the claim administrator may approve a course of treatment that is provided over time or for a specific number of treatments. If the claim administrator later terminates or reduces approval for a course of treatment, it will notify you of this decision so you will have sufficient time to appeal that decision before the course of treatment is reduced or terminated.

If you need to extend a course of treatment and the original request for the treatment was an urgent care claim, you should contact the claim administrator at least 24 hours before the approved course of treatment will expire. If you do so, the claim administrator will provide you with a notice of its decision concerning the requested extension within 24 hours of your request. If you request an extension later, you will receive notice of the claim administrator’s decision based on whether that request is an urgent care or pre-service claim.

Appealing a Denial

If you disagree with a denial, you may request a full review by the claim administrator. You must submit this request within 180 days after you receive the denial notice. In connection with your appeal, you or your representative can review relevant documents and submit issues and comments in writing. See page 22 for a description of the relevant documents you can request. If you want to appeal a decision for benefit level claims, send your appeal the claim administrator listed in the ***Administrative Information*** section of this handbook.

Your appeal will be reviewed and someone other than the person who made the first decision on your claim must make this review. The claim administrator must disclose the identity of any medical or vocational experts who were consulted in connection with your claim. If the benefit decision is based on a medical judgment, the claim administrator must consult with a health care professional who has the appropriate training and experience in the field of medicine involved.

After a decision is made concerning your appeal, you will be notified of its findings and decision in writing. This notice will be provided no later than:

- For an urgent care claim, 72 hours after receiving the appeal
- For a pre-service claim, 30 days after receiving the appeal
- For a post-service claim, 60 days after receiving the appeal

Claims Decisions Notices

The notice given to you concerning the decision on either your initial claim or your appeal will include:

- The specific reason or reasons for the decision
- The specific plan provisions upon which the benefit decision is based
- A description of any additional material or information that is necessary for you to complete your claim and an explanation of why such material or information is necessary
- If an internal rule, guideline, protocol or similar criterion was relied on in making the decision, either a copy of that document, or a statement that such a document was relied upon and that a copy will be furnished (free of charge) upon request
- If the decision is based on a medical limit (for example, a decision that the proposed service is not medically necessary or that it is experimental), either an explanation of the scientific or clinical judgment for the decision (applying the plan's terms to your medical circumstances), or a statement that such an explanation will be provided free of charge upon request
- For an initial claim, a description of the appeal procedures

Please note the claims and appeals processes described in the ***Participation*** section and above do not apply to the Dependent Day Care Account. If your claim for reimbursement under the Dependent Day Care Account is denied, you may appeal the decision to the Administrative Committee of the Waste Management Employee Benefits Plan by sending a written request for review. The Committee will review your claim for reimbursement under the Dependent Day Care Account and notify you in writing of its decision and the reason for it.

Legal Services Plan

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Legal services benefits are available to provide you and your eligible dependents access to personal legal services. If you enroll in this plan, the legal services benefit gives you and your dependents certain personal legal services.

As you read about the legal services benefit, keep in mind the following:

- ➤ Services are provided through a panel of law firms carefully selected by Hyatt Legal Plans
- ➤ Your use of the legal services plan is confidential

A Snapshot of the Legal Services Benefit

The legal services benefit offers assistance with a variety of legal matters. The chart below is a snapshot of the legal services covered.

Area of Law	Covered Legal Services*
Consumer Protection	Disputes over consumer goods Personal property protection Small claims assistance
Debt Matters	Debt collection defense Identity theft defense Personal bankruptcy or wage earner plan Tax audits
Civil Lawsuit Defense	Administrative hearing representation Civil litigation defense Incompetency defense
Document Preparation	Affidavits Deeds Demand letters Mortgages Notes Document review Elder law matters
Family Law	Name change Premarital agreement Uncontested adoption Uncontested guardianship or conservatorship
Personal Injury	Disputes over compensation for personal injuries that you suffer 25% maximum – client pays fee
Real Estate	Eviction and tenant problems Security deposit assistance Property tax assessment on primary residence Refinancing of primary residence Sale or purchase of primary residence
Juvenile and Traffic	Juvenile court defense Traffic ticket defense (excluding DUI and vehicular homicide) Restoration of driving privileges
Wills and Estate Planning	Living trusts Living wills Powers of attorney Probate (10% network discount) Wills and codicils
Immigration Assistance	Advice and consultation

*You must contact Hyatt Legal Plans to determine if your situation is covered. Excludes third party costs.

How the Legal Services Plan Works

You and your dependents have access to confidential legal assistance by calling 800-821-6400, Monday–Friday, 8 a.m. to 7 p.m., Eastern time.

Or, if you prefer, you and your dependents can log on to info.legalplans.com (Code 101155).

When You Contact the Legal Services Plan

When you call the legal services plan, the client service representative who answers your call will:

- Verify your eligibility for services
- Make an initial determination of whether and to what extent your case is covered (the plan attorney will make the final determination of coverage)
- Give you a case number which is similar to a claim number (you will need a new case number for each new case you have)
- Give you the telephone number of the plan attorney located near you (you must contact the plan attorney to schedule a meeting)
- Answer any questions you have about the legal services benefit

If you use the website, you will have access to information regarding covered services, an attorney locator and other legal resources.

Non-Plan Attorneys

Instead of using an attorney who is a member of the Hyatt Legal Plans panel of law firms, you may select your own attorney to handle your case. Or, if there are no Hyatt Legal Plans attorneys located in your area, you may be required to select your own attorney. In either situation, you must call 800-821-6400 and request an out-of-network reimbursement packet.

Plan Attorney Fees

For legal services to be covered, you or your dependents must obtain a case number, retain an attorney, and the attorney must begin work on the covered legal matter while you are covered by the legal services benefit.

Generally, if you use a Hyatt Legal Plans attorney and the legal services provided to you are covered, you will not be responsible for paying attorneys' fees. There are no copayments or deductibles that apply. There are, however, some situations where you are responsible for paying attorney’s fees. For example,

- You may be responsible for fees in certain personal injury cases. See the personal injury section for more details
- You are responsible for fees (after a 10% network discount) related to any probate cases. Please see probate section for more details

If you use a non-Hyatt Legal Plans attorney, the plan will reimburse you for the fees for covered legal services charged by that attorney in accordance with a set fee schedule. You are responsible for any fees over the set schedule amount.

Whether or not you use a Hyatt Legal Plans attorney, you may be required to pay third party costs, such as filing fees, witness fees, etc.

What the Plan Covers

The following briefly describes the legal services that are covered. All benefits are available to you and your spouse and dependents, unless otherwise noted.

Office Consultation and Telephone Advice

- ➤ You may discuss with a plan attorney any personal legal problems that are not specifically excluded
- ➤ The plan attorney will explain your rights and options, and recommend a course of action
- ➤ The plan attorney will identify any further coverage available under the plan, and will undertake representation, if you so request
- ➤ If the plan attorney recommends legal services that are not covered by the plan, the plan attorney will provide you with a written fee statement in advance (you may then choose whether to retain the plan attorney at your own expense, seek outside counsel, or do nothing)
- ➤ You may use this service as often as you wish; however, if the recommended legal services are not covered under the plan, you may not continually seek advice that would allow you to undertake your own representation

Consumer Protection

Consumer Protection Matters

- ➤ Provides representation, including trial, in disputes over consumer goods and services where you are the plaintiff and the contested amount exceeds the small claims limit in that jurisdiction
- ➤ The controversy must be evidenced by a written document such as a sales slip, contract, note or warranty
- ➤ Excludes disputes over real estate, construction, insurance or collection activities after a judgment

Small Claims Assistance

- ➤ Provides counseling to you on pursuing a small claims action
- ➤ Helps you prepare documents
- ➤ Provides advice regarding evidence, documentation, witnesses and preparing for trial
- ➤ Excludes plan attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions

Debt Matters

Debt Collection Defense

- ➤ Includes negotiation with creditors for a repayment schedule and limiting creditor harassment
- ➤ Provides representation in defense of any action for personal debt collection, foreclosure, repossession or garnishment, up to and including trial, if necessary
- ➤ Excludes defense against a judgment, vacating a judgment, counter claims, cross claims, any action arising out of divorce or post decree matters, or any matter where the creditor is affiliated with WM

Identify Theft Defense

- ➤ Provides you with attorney consultations regarding potential creditor actions resulting from identity theft, and attorney services as needed to contact creditors, credit bureaus and financial institutions
- ➤ Provides debt collection defense services as described above
- ➤ Provides you with online help and information about identity theft and prevention

Personal Bankruptcy or Wage Earner Plan

- ➤ Covers you and your spouse in pre-bankruptcy planning, the preparation and filing of a personal bankruptcy or wage earner petition, and representation at all court hearings and trials
- ➤ Excludes coverage if a creditor is affiliated with WM, even if you or your spouse choose to reaffirm that specific debt

Tax Audits

- ➤ Covers reviewing tax returns and answering questions the IRS or a state or local taxing authority has concerning your tax return
- ➤ Includes negotiating with the agency and attending IRS or state or local taxing authority audits
- ➤ Provides advice regarding necessary documentation
- ➤ Excludes prosecuting a claim for the return of overpaid taxes, costs of hiring an accountant or the preparation of any tax returns

Defense of Civil Lawsuits

Administrative Hearing Representation

- ➤ Covers you in defense of civil proceedings before a municipal, county, state or federal administrative board, agency or commission
- ➤ Coverage not available where services are available or are being provided by virtue of a homeowner or vehicle insurance policy
- ➤ Excludes divorce or post-decree matters, paternity, support or custody matters, and litigation concerning job-related incidents

Civil Litigation Defense

- ➤ Covers you in defense of an arbitration proceeding or civil proceeding before a municipal, county, state or federal administrative board, agency or commission, or in a trial court of general jurisdiction
- ➤ Coverage not available where services are available or are being provided by virtue of an insurance policy
- ➤ Excludes divorce or post-decree matters, paternity, support or custody matters, litigation concerning job-related incidents, and bringing counterclaims, third party or cross claims (even when this may be part of the defense)

Incompetency Defense

- ➤ Covers you in the defense of any incompetency action, including court hearings when there is a proceeding to find you incompetent

Document Preparation

Affidavits

- ➤ Covers preparation of any affidavit in which you are the person making the statement

Deeds

- ➤ Covers the preparation of any deed for which you are either the grantor or grantee

Demand Letters

- Covers the preparation of letters that demand money, property or property interest you have, except an interest that is an excluded service
- Includes mailing letters to the addressee, and forwarding and explaining any response to you
- Excludes negotiations and representation in litigation

Document Review

- Covers the review of any personal legal document you may have, such as letters, leases or purchase agreements

Mortgages

- Covers the preparation of any mortgage or deed of trust for which you are the mortgagor
- Excludes documents pertaining to business, commercial or rental property

Notes

- Covers the preparation of any promissory note for which you are the payor or payee

Family Law

Name Change

- Covers all necessary pleadings and court hearings for a legal name change

Prenuptial Agreement

- Covers the preparation of an agreement by a plan member and his or her fiancé prior to their marriage or legal union (where allowed by law), outlining how property is to be divided in the event of separation, divorce or death of a spouse
- Representation is provided only to the WM employee
- The fiancé must have separate counsel or must waive representation

Adoption and Legitimization (Contested and Uncontested)

- This service covers all legal services and court work in a state or federal court for an adoption for the Plan Member and spouse.
- Legitimization of a child for the Plan Member and spouse, including reformation of a birth certificate, is also covered.

Guardianship or Conservatorship (Contested and Uncontested)

- This service covers establishing a guardianship or conservatorship over a person and his or her estate when the Plan Member or spouse is being appointed as guardian or conservator.
- It includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork, attending the hearing and preparing the initial accounting.
- This service does not include representation of the person over whom guardianship or conservatorship is sought, any annual accountings after the initial accounting, or terminating the guardianship or conservatorship once it has been established.

Personal Injury

Personal Injury (May be subject to network fees)

- ➤ Subject to applicable law and court rules, plan attorneys will handle personal injury matters where you are the plaintiff
- ➤ Please note that if you are awarded a judgment in your favor, you will be responsible for paying a fee to the attorney based on your award (up to 25% of the gross award)
- ➤ For payments to a third party, see Exclusions

Real Estate Matters

Eviction and Tenant Problems (Primary Residence – Tenant Only)

- ➤ Covers you as a tenant for matters involving leases, security deposits or disputes with a residential landlord
- ➤ Includes eviction defense, up to and including trial
- ➤ Excludes representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of a security deposit

Security Deposit Assistance (Primary Residence – Tenant Only)

- ➤ Covers counseling services for you, as a tenant, attempting to recover a security deposit from your residential landlord
- ➤ Includes reviewing the lease and other relevant documents, and preparing a demand letter to the landlord for the return of the deposit
- ➤ Includes assistance in prosecuting a small claims action, helping prepare documents, advising on evidence, documentation and witnesses, and preparing you for a small claims trial
- ➤ Excludes the plan attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions

Property Tax Assessment (Primary Residence)

- ➤ Covers the administrative appeal, by an attorney representing you, of a property tax assessment on your primary residence
- ➤ Includes gathering the necessary evidence, filing the necessary documents, negotiating a settlement, and attending any necessary hearings to see a reduction of the assessment

Refinancing of Home (Primary Residence)

- ➤ Covers the review or preparation, by an attorney representing you, of all relevant documents (including the mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of your primary residence
- ➤ Includes obtaining a permanent mortgage on a newly constructed home
- ➤ Excludes services provided by any attorney representing a lending institution or title company
- ➤ Excludes the refinancing of a second home, vacation property, rental property and property held for business or investment

Sale or Purchase of Home (Primary Residence)

- Covers the review or preparation, by an attorney representing you, of all relevant documents (including the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of your primary residence
- Includes attendance of an attorney at closing
- Excludes services provided by any attorney representing a lending institution or title company
- Excludes the sale or purchase of a second home, vacation property, rental property, property held for business or investment or leases with an option to buy

Traffic and Juvenile Matters

Juvenile Court Defense

- Covers the defense of a WM employee and a WM employee's dependent child in any juvenile court matter, provided there is no conflict of interest with the WM employee
- If there is a conflict of interest with the WM employee, then this service provides an attorney for the WM employee only

Traffic Ticket Defense (Not DUI)

- Covers representation of you in defense of most traffic tickets, including court hearings, negotiation with the prosecutor and trial
- Excludes traffic tickets related to driving under the influence and vehicular homicide

Restoration of Driving Privileges

- Provides representation in proceedings to restore your driving license

Wills and Estate Planning

Living Trusts

- Covers the preparation of a living trust for you
- Excludes tax planning or services associated with funding the trust after it is created

Living Wills

- Covers the preparation of a living will for you

Powers of Attorney

- Covers the preparation of any power of attorney when you are granting the power

Probate (10% Network Discount)

- Subject to applicable law and court rules, plan attorneys will handle probate matters at a fee 10% less than the plan attorney’s normal fee
- You must pay this reduced fee and all costs

Wills and Codicils

- Covers the preparation of a will for you
- Includes the creation of any testamentary trust, the preparation of codicils and will amendments
- Excludes tax planning

Immigration Assistance

- Covers advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents and helping you prepare for hearings

Elder Law Matters

- Covers counseling over the phone or in the office on any personal issues relating to your parents as they effect you
- Includes reviewing your parents' documents to determine the impact on you, including Medicare or Medicaid materials, prescription drug plans, leases, nursing home agreements, powers of attorney, living wills and wills
- Includes preparing deeds for your parents if you are the grantor or grantee
- Includes preparing promissory notes for your parents if you are the payor or payee

Personal Property Protection

Covers counseling over the phone or in the office on any personal property issue such as consumer credit reports, contracts for the purchase of personal property, consumer credit agreements or installment sales agreements.

- Includes counseling on pursuing or defending small claims actions
- Includes reviewing any personal legal documents and preparing promissory notes, affidavits and demand letters

Exclusions

Certain legal matters are excluded from coverage under the legal services benefit. No services, not even a consultation, can be provided for the following matters or items:

- Appeals or class actions
- Business, farm, patent, trademark or copyright matters
- Matters for which an attorney client relationship exists before the participant becomes eligible for plan benefits
- Matters or disputes involving WM, Hyatt Legal Plans, MetLife or a plan attorney
- Matters concerning employment including WM and statutory benefits
- Matters in which there is a conflict of interest between the WM employee and his or her spouse or dependents (services are excluded for the spouse and dependents), for example, divorce
- Frivolous or unethical matters
- Payments made to a third party such as costs, witness fees, filing fees or fines

Confidentiality, Ethics and Independent Judgment

Your use of these legal services is confidential. The plan attorney will maintain strict confidentiality of the traditional lawyer-client relationship. WM will know nothing about your legal problems or the services you use under the plan. The Administrative Committee will have access only to limited statistical information needed for orderly administration of the plan.

No one will interfere with your plan attorney's independent exercise of professional judgment when representing you. All attorneys' services provided under the plan are subject to ethical rules established by the courts for lawyers. The attorney will adhere to the rules of the plan and she or he will not receive any further instructions, direction or interference from anyone else connected with the plan. The attorney's obligations are exclusively to you. The attorney's relationship is exclusively with you. Hyatt Legal Plans, Inc., or the law firm providing services under the plan is responsible for all services provided by their attorneys.

You should understand that the plan has no liability for the conduct of any plan attorney. You have the right to file a complaint with the state bar concerning attorney conduct under the plan. You will have the right to retain, at your own expense, any attorney authorized to practice law in your state.

Plan attorneys will refuse to provide services if the matter is clearly without merit, frivolous or for the purpose of harassing another person. If you have a complaint about the legal services you have received or the conduct of an attorney, you can call 800-821-6400.Your complaint will be reviewed and you will receive a response within two business days of your call.

Important Rules to Keep in Mind

In addition to the coverage and exclusions described above, there are certain rules for special situations. Please read this section carefully.

If Other Coverage is Available to You

If you are entitled to receive legal representation provided by any other organization such as a government agency, or if you are entitled to legal services under any other legal plan, coverage will not be provided under this plan. However, if you are eligible for legal aid or Public Defender services, you will still be eligible for benefits under this plan, so long as you meet the eligibility requirements.

If a WM Employee is Involved in a Legal Dispute with His or Her Dependents

If you have a case where you need legal help related to a problem involving your spouse or your children, only you (the WM employee) will be entitled to representation by a plan attorney. Or, if both you and your dependent need representation and it would be improper, based on the situation, for one attorney to represent both you and your dependent, only you will be entitled to representation by the plan attorney. In these circumstances, your dependent will not be covered under the plan.

If You are Involved in a Legal Dispute with Another WM Employee Covered Under the Plan

If you or your dependents are involved in a dispute with another WM employee covered by the plan, or that employee's dependents covered by the plan, Hyatt Legal Plans will arrange for legal representation with independent and separate counsel for both parties.

If the Court Awards Attorneys' Fees as Part of a Settlement

If you are awarded attorneys' fees as a part of a court settlement, the plan must be repaid from this award to the extent that it paid the fee for your attorney.

Portability

If you are enrolled in the Legal Services Plan and your employment with WM terminates, you can continue your coverage for 30 months. To do so, you must contact Hyatt Legal Plans' Client Service Center at 800-821-6400 within 31 days of your termination date and indicate that you want to continue your coverage. To continue your coverage, you must pay upfront an amount equal to the monthly group legal plan rate times the number of months in the continuation period (currently 30 months). This amount is paid directly to Hyatt Legal Plans. Coverage during the continuation period will be the same as the coverage before termination of employment.

Applying for Benefits

If you use a non-Hyatt Legal Plans attorney, you can request your reimbursement by calling Hyatt Legal Plans at 800-821-6400 and requesting a fee reimbursement form. You then complete the fee reimbursement form and return it to Hyatt Legal Plans along with the itemized attorney's bill showing that you have paid for the services.

Please refer to page 22 of the ***Participation*** section for more information on eligibility and enrollment claims.

If you have any questions about benefits paid or denied, you should contact Hyatt Legal Plans and try to work out the problem. If you are not satisfied with the response, you should send a written request for benefits to Hyatt Legal Plans. If Hyatt Legal Plans again denies your claim for benefit, it will send you a notice. This notice will include reference to the specific plan provision on which the benefit decision was based and a description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary. The notice will generally be given within 90 days unless the insurance company notifies you in writing that an extension (not to exceed 90 days) is needed.

If you believe the denial is still incorrect, you may request a fully and fair review by Hyatt Legal Plans within 60 days after you received the notice. In connection with your appeal, you or your representative can review relevant documents and submit issues and comment in writing. See page 22 of the ***Participation*** section for details on the relevant documents that must be made available to you.

Hyatt Legal Plans will review all disputed claims and will notify you of its findings and decision in writing within 60 days (unless special circumstances require an extension not to exceed an additional 60 days) after it receives the appeal. Your notification will include reasons for the decision and references to the plan provision on which the decision is based.

Claim Filing Deadline

If you use a non-Hyatt Legal Plans attorney, you have up to one year from the date the attorney provided the services to file your claim for payment. Claims filed or received after one year are not eligible for reimbursement. Therefore, you should file claims promptly after the services are provided.

Adoption Assistance

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This WM program provides eligible employees with assistance in paying eligible expenses incurred in connection with the legal adoption of a child. As you read about the Adoption Assistance Program, keep the following in mind:

- Only eligible expenses incurred while you are an eligible employee are reimbursable
- The Adoption Assistance Program is a reimbursement program. Under the program, you are reimbursed for eligible expenses only after you pay the expenses and only after the adoption is completed. The program does not advance you money to pay outstanding bills
- The reimbursement received may be taxable to you and it may reduce any tax credits available. You should consult your own tax professional for advice
- The program is designed to help you pay eligible expenses associated with the legal adoption of a child
- The program covers only eligible expenses up to $5,000 and only if the adoption is ultimately successful

Note: This program is not subject to ERISA.

How Your Adoption Assistance Program Works

The Adoption Assistance Program provides for reimbursement of eligible expenses incurred in connection with the legal adoption of a child.

What You Need to Do

To make the Adoption Assistance Program work for you:

- Legally and successfully adopt an eligible child. Any reimbursement for eligible expenses is subject to the completion of a legal adoption of an eligible child. To receive any reimbursement, you must provide WM with written confirmation from your attorney or other person acceptable to WM certifying that you have completed a legal adoption of an eligible child (the “Adoption Certification”)
- Incur eligible expenses. You are reimbursed only for expenses you actually incur. You must provide written proof that you have paid all eligible expenses. So, be sure to get receipts for all eligible expenses. The program will not reimburse you for any expense you incurred before you become an eligible employee, after you end your employment with WM, or after the termination of the program. See page 153 for a list of eligible and non-eligible expenses
- Receive reimbursement. You must submit an adoption assistance reimbursement form along with receipts for all claimed eligible expenses and the Adoption Certification to the WMSC

A Word About Taxes

Pursuant to Section 137 of the Internal Revenue Code, in most cases the money reimbursed to you is not subject to federal income taxes. Similarly, the money reimbursed to you is normally not subject to state and local income taxes either. It is, however, subject to social security (FICA) taxes. If your adjusted gross income is more than $150,000, some or all of your reimbursement will be subject to federal income taxes. If you think this rule applies, you should consult a tax advisor.

Rules vary, and state and local laws are subject to frequent change. WM may be required to withhold taxes on any reimbursement and will do so if it determines the law requires it.

Eligible Child

You and your spouse may use the Adoption Assistance Program only if you adopt an eligible child. A child is an “eligible child” if he or she is under the age of 18 and is not your biological child.

Eligible Expenses

The term “eligible expense” means any reasonable and necessary adoption fees, court costs, attorneys’ fees, and other expenses that are incurred by you and directly relate to the legal adoption of an eligible child. The following are examples of expenses that may be reimbursed under the Adoption Assistance Program.

- Private or public adoption agency fees
- Hospitalization and other medical costs of the natural (birth) mother and child if you legally assume such costs under the terms and conditions of the adoption agreement
- Court costs
- Your attorney’s fees
- Placement fees

Expenses Not Covered

The program does not reimburse you for certain expenses. The term “eligible expense” does not include costs:

- Incurred in violation of any law or in carrying out any surrogate parent agreement
- Reimbursed under another WM plan or program, under your spouse’s employer’s plans or benefits, by any other third party
- Incurred when you were not an employee of WM or you were not eligible

Applying for Reimbursement

To apply for reimbursement, you must file the following with the WMSC:

- An adoption assistance reimbursement form
- Receipts for all the expenses you are claiming
- The Adoption Certification

You can be reimbursed under the Adoption Assistance Program only after:

- The service or item for which you are seeking reimbursement has been performed
- You have paid for the service or item
- The legal adoption of an eligible child has been successfully completed
- You have been reimbursed from all other sources legally obligated to provide reimbursement

Claim Filing Deadline

You may file a claim only after the completion of the legal adoption of an eligible child. You must submit a claim by April 30 of the year following the year in which the adoption is completed. Claims filed or received after April 30 are not eligible for reimbursement. Therefore, you should file claims promptly after the completion of the adoption. Claim forms can be obtained from WMVisor, by calling the WMSC or online at mywmtotalrewards.com.

If a Claim is Denied

If disagreements arise regarding your claim, every effort is made to resolve them quickly and informally. However, if an informal resolution is not made, you may appeal a decision to the Administrative Committee of the Waste Management Employee Benefits Plan by sending a written request for review. The Committee will review your request and notify you in writing of its decision and the reasons for it. (Note that the formal claim review procedures described in the ***Participation*** section do not apply to this program.)

Business Travel Accident

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While you are working, you and your dependents rely on your paycheck to meet day-to-day expenses. If you die or are seriously injured in a covered accident while traveling on business for WM, your dependents' financial security could be seriously affected. The Company automatically provides you with business travel accident coverage. You or your designated beneficiary are eligible for financial assistance if you die or suffer a covered loss as a result of a covered accident while traveling on a business trip that is paid for and approved by WM.

A Snapshot of the Business Travel Accident Coverage

The chart below is a snapshot of the business travel accident coverage.

Accidental Death and Dismemberment Benefit

	Coverage Amount (Principal Sum)
Employee	5 times annual pay (up to $1,000,000)
Dependent Spouse*	$250,000

* A dependent spouse is covered only if WM is paying the dependent spouse's travel expenses.

Disability Benefit

	Coverage Amount
Employee	1% of principal sum per month up to $100 per month

Maximum

The maximum amount the insurer will pay for any one accident is $5,000,000. If this limit is triggered, the benefits provided to each covered individual for that accident will be reduced proportionally.

Annual Pay

If you are an employee, your annual pay determines the amount of your business travel accident coverage. "Annual pay" means your hourly rate times 40 hours times 52 weeks – or your annual pay plus eligible commissions. It does not include bonuses or overtime pay.

If You Are Age 70 or Older

If you are age 70 or older and still actively working, your business travel accident coverage is reduced starting at age 70. The percentage reduction is applied to the coverage in effect on the day before your 70th birthday. The chart below shows the percentage of coverage that remains at each age. Coverage for your dependent ends when you reach age 70.

Age	Percentage Remaining*
70-74	70%
75-79	45%
80-84	30%
85 and older	15%

*The percentage is applied to the coverage in effect on the day before your 70th birthday.

How the Business Travel Accident Coverage Works

This section provides a brief overview of how the business travel accident coverage works.
The business travel accident coverage provides benefits to you or your designated beneficiary if you are traveling on business for WM and are involved in a covered accident that results in your death, dismemberment or disability.

Coverage under the business travel accident plan begins at the actual start of a trip, regardless of whether the trip starts at your home, your work place or other place. Coverage ends when you:

- Arrive at your home or place of work, whichever happens first; or
- Make a personal deviation

A personal deviation is any activity that is not reasonably related to WM's business and not incidental to your business trip. Coverage does not apply while you are commuting between your home and place of work or during personal travel.

An accidental death, dismemberment loss, or permanent and total disability must be the direct result of injuries sustained while traveling on business for WM and cannot be a result of any other cause. To be covered, the death, dismemberment loss, or permanent and total disability must occur within one year of the covered accident.

Who is Covered

You have business travel accident insurance if you are one of the following:

- An active, full-time salaried or non-operation clerical employee (excluding pilots)
- An active, full-time employee pilot, while operating an aircraft and while not involved in the operation of an aircraft for WM
- Guests and spouses, if WM is paying the guest's or spouse's travel expenses

Eligibility for Business Travel Accident Benefits

To be eligible for business travel accident benefits, all of the following requirements must be satisfied:

- ➤ You must be involved in a covered accident while coverage is in effect
- ➤ You must be involved in a covered accident that occurs while you are traveling on a business trip that is paid for and approved by WM
- ➤ The covered accident must be the sole cause of the injury
- ➤ The injury must be the sole cause of the covered loss (covered losses are shown in the schedule)
- ➤ You must have experienced the covered loss within one year after the date of the covered accident

Business Travel Accidental Death & Dismemberment

Your business travel accidental death and dismemberment coverage is highlighted in the snapshot chart on page 156.

The Coverage

Your business travel accidental death and dismemberment coverage pays benefits to your beneficiary if you die as a result of a covered accident that occurs while you are on a business trip that is paid for and approved by WM. You receive benefits if you suffer a covered loss due to an accident-related injury that occurs while you are on a covered business trip.

You receive benefits if your dependent spouse dies as a result of a covered accident while on a covered business trip. Your dependent spouse receives benefits if your dependent spouse suffers a covered loss due to an accident-related injury that occurs while on a covered business trip.

Covered Business Travel Accident Losses

The following chart highlights the schedule of benefits if you or your dependent spouse experience a covered loss after a covered accident.

Schedule of Benefits for Covered Business Travel Accident Losses

Covered Loss	Percent of Principal Sum	Amount Payable
Life	100%	To beneficiary
Sight in both eyes	100%	To you
Both hands	100%	To you
Both feet	100%	To you
One hand and one foot	100%	To you
One hand or one foot and sight in one eye	100%	To you
Speech and hearing (in both ears)	100%	To you
Total paralysis of both upper and lower limbs	100%	To you
Total paralysis of both lower limbs	50%	To you
Total paralysis of upper and lower limbs on one side of the body	50%	To you
Speech or hearing in both ears	50%	To you
One hand	50%	To you
One foot	50%	To you
Sight in one eye	50%	To you
Thumb and index finger on the same hand	25%	To you

In the event of multiple losses from one covered accident, you receive business travel accident benefits for the loss with the larger benefit.

Losses Defined

The plan defines covered losses as:

- Loss of sight – total and irrecoverable loss of sight
- Loss of hand or foot – complete severance through or above the wrist or ankle joint
- Loss of speech – complete inability to communicate audibly in any degree
- Loss of hearing – irrecoverable loss of hearing which cannot be corrected by any hearing aid or device
- Loss of thumb or index finger – the actual severance of either or both through or above the joint closest to the wrist; in California, complete severance of at least one whole phalanx of each
- Paralysis – loss of use (without severance) of a limb. A medical authority must determine the paralysis to be complete and irreversible
- Severance – complete separation and dismemberment of the limb from the body

Disability Benefit

Your business travel accident disability coverage is highlighted in the snapshot chart on page 156. Additional information on this coverage follows.

The Coverage

Your business travel accident disability coverage pays you benefits if you meet all of the following requirements:

- You suffer a covered loss as a result of an injury from a covered accident
- You become disabled as a direct result, and from no other cause, within one year of the covered accident
- You remain disabled for 12 straight months
- You are then permanently and totally disabled

You will receive 1% of the principal sum (up to $100) each month until you die or are no longer permanently and totally disabled. However, your coverage amount will be reduced by the amount of any benefits paid under the business travel accidental dismemberment coverage. The maximum amount of benefits (under the accidental death and dismemberment benefit and the disability benefit) that will be paid for any one covered accident is equal to the principal sum, as shown in the snapshot chart on page 156.

Disabled

You are “disabled” if you cannot do all of the substantial and material duties of your type of work. You are “permanently and totally disabled” if you are not able to do any work for which you are or may become qualified by reason of your education, experience or training, and if you are not expected to be able to do any work for the rest of your life.

This coverage coordinates with your long-term disability benefits.

Special Benefits

The information below highlights the special benefits available under your business travel accident coverage.

Coma Benefit

If you become comatose within 31 days of a covered accident, and remain comatose for more than 31 days (waiting period), you will receive 1% of your principal sum per month beginning at the end of the waiting period. This benefit will stop on the earliest of:

- The end of the month in which you die
- The end of the 11th month for which this benefit is paid
- The end of the month in which you recover from the coma

You are comatose if you are in a profound stupor or state of complete and total unconsciousness as a result of a covered accident.

If coma benefits are payable, disability benefits will not be payable.

If you die as a result of the covered accident while the coma benefit is payable, or remain comatose after this coma benefit is payable for 11 straight months, you or your beneficiary will receive a lump sum benefit equal to your principal sum reduced by any amount payable under the accidental dismemberment policy for a covered loss caused by the accident. After the lump sum benefit is paid, benefits will not be paid under the business travel accident coverage for accidental death.

In addition to the general exclusions described on page 162, this coma benefit will not be provided for any loss resulting from sickness, disease, bodily injuries or medical or surgical treatment thereof, or bacterial or viral infection.

Carjacking Benefit

If your covered loss is a result of a carjacking while you are operating or riding in that vehicle, you will receive the lesser of $1,000 or 100% of the largest benefit payable under any of the benefits available under this policy for the loss. Only one benefit is payable for all losses resulting from the same carjacking (subject to police verification).

Carjacking means the unlawful possession of an automobile by force or threats against the person(s) then rightfully occupying such automobile. An automobile does not include a mobile home or any motor vehicle used in mass or public transportation.

Home Alteration and Vehicle Modification Benefit

You will receive reimbursement for covered home alteration and vehicle modification expenses if you:

- Suffer an accidental dismemberment for which benefits are payable under the policy
- Did not, prior to the date of the covered accident causing the loss, require the use of a wheelchair to be ambulatory
- As a direct result of such loss are now required to use a wheelchair to be ambulatory

The covered home alteration and vehicle modification expenses must be incurred within one year after the date of the covered accident causing such loss. Reimbursement for these expenses is limited to the lesser of 10% of the principal sum or $25,000.

Covered home alteration and vehicle modification expenses mean onetime expenses that:

- Are charged for alterations to your residence that are necessary to make the residence accessible and habitable for a wheelchair-confined person or a modification to your motor vehicle (owned or leased) or a newly purchased motor vehicle that are necessary to make the vehicle accessible to and/or driveable by you
- Do not include charges that would not have been made if no insurance existed
- Do not exceed the usual level of charges for similar alterations and modifications in the locality where the expense is incurred

The alterations to your residence or modifications to your motor vehicle must be:

- Made on your behalf
- Recommended by a nationally recognized organization providing support and assistance to wheelchair users
- Carried out by individuals experienced in such alterations and modifications
- In compliance with any applicable laws or requirements for approval by the appropriate government entities

Home alteration and vehicle modification expenses do not include those resulting from any condition for which you are entitled to benefits under any workers' compensation act or similar law.

This benefit is not payable for expenses that result from any condition for which you are entitled to benefits under any workers' compensation act or similar law.

Rehabilitation Benefit

If you suffer a loss for which benefits are payable under the business travel accident coverage, you will be reimbursed for covered rehabilitative expenses that are due to the injury causing the loss. The covered rehabilitative expenses must be incurred within two years after the date of the accident causing the injury.

The rehabilitative expenses are limited to $2,500 for all injuries caused by the same accident. Covered rehabilitative expenses include expenses that:

- Are charged for medically necessary rehabilitative training services performed under the care, supervision or order of a doctor
- Do not exceed the usual level of charges for similar treatment, supplies or services in the locality where the expense is incurred
- Do not include charges that would not have been made if no insurance existed

Medically necessary rehabilitative training service means any medical service, supply or treatment or hospital confinement that:

- Is essential for physical rehabilitative training as a result of an injury for which it is prescribed or performed
- Meets generally accepted standards of medical practice
- Is ordered by a doctor

Rehabilitative expenses do not include any expenses for or resulting from any condition for which you are entitled to benefits under any workers' compensation act or similar law.

Seat Belt Benefit

If you die as a result of a covered accident while you are operating or riding as a passenger in an automobile and wearing a properly fastened, original, factory-installed seat belt (subject to police verification), your beneficiary will receive $25,000.

An automobile does not include a mobile home or any motor vehicle used in mass or public transportation.

Felonious Assault

You or your beneficiary will receive an additional benefit of 25% of the principal sum if you are injured or die while on the business or any premises of the company, and your injury or death is the direct result of any of the following:

- Robbery, holdup or attempt threat
- Kidnapping attending a holdup
- Felonious assault inflicted by persons other than fellow employees

Exclusions

You or your beneficiary do not receive benefits for any loss that is caused by or results from any of the following:

- Suicide, attempted suicide, or whenever you injure yourself on purpose, while sane or insane; in Missouri, this exclusion does not apply if you are insane
- War or acts of war, whether or not declared
- Injury while you are on full-time active duty in any armed forces
- Taking part in a felony
- Travel or flight in any spacecraft
- Any bacterial infection that was not caused by an accidental cut, wound or food poisoning
- Illness, disease or bodily infirmity not caused by a covered accident
- Travel or flight in any aircraft being used for operations requiring a special permit or waiver from the Federal Aviation Administration, even if the permit or waiver is granted
- Travel or flight in any aircraft being used for crop-dusting, crop-spraying, seeding, firefighting, skywriting, sky diving, hang gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, or stunt or acrobatic flying

Situations Affecting Your Business Travel Accident Coverage

Certain situations could affect your business travel accident coverage. For additional information on how long these coverages continue, see page 17 of the ***Participation*** section.

Applying for Benefits

If you experience a covered loss, you or your beneficiary must send written notice to Life Insurance Company of North America within 30 days of the covered loss, or as soon after that as is reasonably possible. The notice should include your name and the policy number (ABL660449). Life Insurance Company of North America will send you a claim form.

How to File Claims

The claim form must be returned within 90 days after a covered loss occurs or ends, or as soon as reasonably possible after that. If no claim form is received from Life Insurance Company of North America, you must send other proof of loss by the date the claim form would be due. The proof of loss should include written proof of the occurrence, type and amount of loss.

Deadline for Filing a Claim

You have up to one year from the date of the covered loss or death to file your claim for payment. Claims filed or received after one year are not eligible for benefits.

When Benefits Are Paid

Benefits are paid as soon as proof of loss is received. If a claim covers benefits for more than four weeks, payments will be made at the end of each four weeks.

Filing a Claim

Please refer to page 22 of the ***Participation*** section for more information on eligibility and enrollment claims.

If you have any questions about benefits paid or denied, you should contact the insurance company and try to work out the problem. If you are not satisfied with the response, you should send a written request for benefit to the insurance company. If the insurance company denies your claim for benefit, it will send you a notice. This notice will include reference to the specific plan provision on which the benefit decision was based and a description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary. The notice will generally be given within 90 days unless the insurance company notifies you in writing that an extension (not to exceed 90 days) is needed.

If you believe the denial is still incorrect, you may request a fully and fair review by the insurance company within 60 days after you received the notice. In connection with your appeal, you or your representative can review relevant documents and submit issues and comment in writing. See page 22 of the ***Participation*** section for details on the relevant documents that must be made available to you.

The insurance company will review all disputed claims and will notify you of its findings and decision in writing within 60 days (unless special circumstances require an extension not to exceed an additional 60 days) after it receives the appeal. Your notification will include reasons for the decision and references to the plan provision on which the decision is based.

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The Waste Management Health and Welfare Benefits Plan is governed by ERISA (the Employee Retirement Income Security Act of 1974). Note, however, that the Short-Term Disability Program, the Adoption Assistance Program and the Dependent Day Care Flexible Spending Account Program are not subject to ERISA. This section provides important legal and administrative information you may need, including:

- How to identify the plan and each component of the plan
- Information about the claim administrators (i.e., insurance companies and third-party administrators) that provide or administer benefits and how to contact them
- Who the Plan Administrator is and how to contact the Plan Administrator
- Other important information you may need to know regarding your health and welfare benefits

If you have any questions about the administrative details surrounding the plan, please contact the Benefits Center.

Administrative Information

Official Plan Name

When dealing with or referring to your health and welfare benefits (for example in the event of a claim appeal or other correspondence), you will receive a more rapid response if you identify the plan fully and accurately. The official name of the plan is the Waste Management Health and Welfare Benefits Plan.

Important Contact Information

You may contact the Benefits Center at 800-964-3373. Information regarding the plan is available on mywmtotalrewards.com.

The following chart includes important contact information for the claim administrators for the self-insured benefit coverages and for the insurance companies for the vision, long-term disability, life and AD&D, legal services and business travel accident coverages (the insured coverages).

Benefit Plan	Plan Number	Insurance Company or Claim administrator
Medical **Build Your Own and** **HDHP/HSA options**	516	Cigna P.O. Box 182223 Chattanooga, TN 37422 800-545-6534 myCigna.com / Cigna.com
Medical **EPO option (including** **mental health and substance** **abuse)**	516	Blue Cross Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044 800-496-3907 bcbstx.com/wm
EFAP/Mental **Health/Substance Abuse** **(behavioral health: Build** **Your Own & HDHP options)**	516	Cigna Behavioral Health (CBH) P.O. Box 46270 Eden Prairie, MN 55344-6270 800-862-3558
Prescription Drug	516	Catamaran Rx Appeal P.O. Box 371544 Las Vegas, NV 89134 855-209-1293 Fax: 888-826-7406

Benefit Plan	Plan Number	Insurance Company or Claim administrator
Dental	516	Delta Dental of Illinois P.O. Box Lisle, IL 60532 800-398-7203 deltadentalil.com
Vision	516	Vision Service Plan (VSP) 3333 Quality Drive Rancho Cordova, CA 95670 800-877-7195 vsp.com
Flexible Spending Accounts	516	Hewitt P.O. Box 785040 Orlando, FL 32878-5040 800-964-3373 mywmtotalrewards.com
Life and AD&D **Basic Employee and Dependent Life** **Optional Employee and Dependent Life** **Basic Employee and Dependent AD&D** **Optional Employee and Dependent AD&D**	516	Metropolitan Life Insurance Company Five Park Plaza, Suite 1900 Irvine, CA 92614 888-801-9142 MetLife.com
Short-Term Disability (claims related) **Long-Term Disability**	516	Life Insurance Company of North America 12225 Greenville Avenue, Suite 1000 Dallas, TX 75243 Cigna.com 877-216-8677
Legal Services	516	Hyatt Legal Plans, Inc. Eaton Center 1111 Superior Avenue, Suite 800 Cleveland, OH 44114-2407 800-821-6400 info.legalplans.com (code 100010)
Business Travel Accident	516	Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192

Plan Sponsor

Waste Management, Inc.
1001 Fannin Street, Suite 4000
Houston, TX 77002
713-512-6200

Waste Management, Inc. is the plan sponsor for purposes of ERISA.

Plan Administrator

Administrative Committee of the Waste Management Employee Benefits Plan
Waste Management, Inc.
1001 Fannin Street, Suite 4000
Houston, TX 77002
713-512-6200

The Administrative Committee of the Waste Management Employee Benefits Plan is the Plan Administrator for purposes of ERISA. The Committee (or claim administrator) has the discretionary authority to grant or deny benefits under the plan, administer the plan, including (but not limited to), interpreting the plan's provisions, making factual determinations, and determining who is eligible for benefits. However, the insurance companies have sole discretionary authority to grant or deny benefits under insured plans, and to make benefit determinations in accordance with the terms of the policies they have issued to WM. Benefits will be paid only if the claim administrator, Plan Administrator or insurance company (whichever is applicable) decides in its discretion that the applicant is entitled to them. All decisions of the Plan Administrator and the insurers/claim administrators are conclusive and binding on all parties. If you have questions about the plan, first call the appropriate claim administrator or insurance carrier, then call the Benefits Center at 800-964-3373, or finally, your local Human Resources representative. If these parties cannot answer your question, you may contact the Plan Administrator at the address or phone number shown above.

Employer Identification Number

The employer identification number (EIN) for Waste Management, Inc. is 73-1309529.

Participating Affiliates

Waste Management, Inc. (the "Company") and its participating affiliates and employers sponsor the plan. You can request a list of participating affiliates and employers by writing to the Plan Administrator.

Plan Year

For recordkeeping and accounting purposes, the plan is operated on a calendar-year basis (January 1 through December 31).

Contributions

The medical (except the fully insured HMOs), prescription drug, dental, EFAP/mental health and short-term disability plans are self-insured by WM. The amount you must contribute, if any, depends on the coverage you select. All benefits under the vision, long-term disability, life, AD&D, legal services benefit, and business travel accident plans are provided through insurance contracts with the insurers listed on pages 166-167. Insurance premiums are paid through a combination of employer assets and contributions by participants, as shown on page 1.

Certificate of Creditable Coverage

When your or your dependents' coverage under the medical, dental or vision coverage ends, the plan automatically provides you or your dependents with a certificate of creditable coverage. If you or your dependents elect COBRA continuation coverage, another certificate of creditable coverage is provided when COBRA continuation coverage ends. These certificates are important because they may enable you to reduce any pre-existing condition exclusion period under the plan of your next employer. You should keep the certificate with your other important papers. If you do not receive a certificate, or if you lose your certificate, you may request another one by contacting the Plan Administrator within 24 months after your coverage ends.

Collective Bargaining Agreements

This plan is maintained pursuant to one or more collective bargaining agreements. If you are covered by such an agreement, you or your beneficiary may obtain a copy of the applicable collective bargaining agreement by written request to the Plan Administrator.

Agent for Service of Legal Process

The agent for service of legal process on the plan is the plan sponsor:

Waste Management, Inc.
Attn: Vice President, Assistant General Counsel – Labor, Employment, and Benefits
1001 Fannin Street Suite 4000
Houston, TX 77002

Legal process on the plan also may be served on the Plan Administrator at the above address.

Permanency of the Plan

Waste Management, Inc. intends to continue the plan indefinitely. However, the Company reserves the right to make changes to the benefits provided under the plan, or even terminate the plan or any of the benefits provided under the plan. You have the right to convert or take with you certain coverages if your group coverage ends.

Official Plan Documents

Every attempt has been made to make this as detailed a handbook as possible. However, if this handbook inadvertently says anything that disagrees with the official plan document or insurance contract that governs each component of the plan, the plan document or insurance contract is followed to determine your benefits.

Your ERISA Rights

As a participant in the Health and Welfare Benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan participants shall be entitled to the following:

Receive Information About Your Plan and Benefits

Examine (without charge) at the Plan Administrator's office and at other specified locations such as work sites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may impose a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

You also have the right to:

- 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 under COBRA. You or your dependents will have to pay for such coverage. Review this summary plan description and the documents governing the plan for the rules governing your COBRA continuation coverage rights
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under that plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties on the people who are responsible for the operation of the plan. The people who operate the plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your ERISA rights.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials – unless the materials were not sent for reasons beyond the control of the Plan Administrator
- If you have a claim for benefits that is denied or ignored – in whole or in part – after going through the appeals procedures, you may file suit in a state or federal court
- If you disagree with the plan's decision or lack of response to your request concerning the qualified status of a QMCSO, you may file suit in federal court
- If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court
- If you file suit against the plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees – if, for example, it finds your claim is frivolous

Assistance with Your Questions

If you have any questions about the plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration Brochure Request Line at 800-998-7542, on the Internet at http://dol.gov/dol/ebsa/public/pubs/main.htm, or by contacting the EBSA field office nearest you.

Notice of Privacy Practices

Revised: January 1, 2011

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.

General Information About This Notice

Waste Management, Inc. ("WM") continues its commitment to maintaining the confidentiality of your private medical information. This Notice describes the legal obligations of the group health plans maintained by WM under the Health and Welfare Benefits Plan imposed by the Health Insurance Portability and Accountability Act of 1996, the American Recovery and Reinvestment Act of 2009 and accompanying regulations (the "Privacy Rules") regarding your health information. The Privacy Rules require that the plans use and disclose your health information only as described in this Notice. This Notice only applies to health-related information received by or on behalf of the WM plans listed below.

This Notice applies to WM employees, former employees, and dependents who participate in any of the following benefit programs under the Plans ("Health Plans"):

- Medical benefits
- Dental benefits
- Prescription drug coverage

- Health care flexible spending account program
- Employee and family assistance program
- Wellness program

In this Notice, the terms “we,” “us,” and “our” refer to the Health Plans (listed above), all WM employees involved in the administration of the Health Plans, and all third parties who perform services for the Health Plans. Actions by or obligations of the Health Plans include these WM employees and third parties.

However, WM employees perform only limited Health Plan functions – most Health Plan administrative functions are performed by third party service providers.

Please note: This Notice does not apply to insured benefits including benefits provided through an insurance arrangement. If you are enrolled in an insured option, such as an HMO, you will receive a separate notice from that provider.

What is Protected?

Contact Information

If you have any questions regarding this notice, please contact:

Waste Management
1001 Fannin, Suite 4000
Houston, TX 77002

Attn: HIPAA Privacy Officer

phone: 800-964-3373
fax: 713-394-5190

Federal law requires the Health Plans to have a special policy for safeguarding a category of medical information received or created in the course of administering the WM Health Plans, called “protected health information,” or “PHI”. PHI is health information (including genetic information) that can be used to identify you and that relates to:

- your physical or mental health condition,
- the provision of health care to you, or
- payment for your health care.

Your medical and dental records, your claims for medical and dental benefits, and the explanations of benefits (“EOB’s”) sent in connection with payment of your claims are all examples of PHI.

If WM obtains your health information in another way – for example, if you are hurt in a work accident or if you provide medical records with your request for Family and Medical Leave Act (FMLA) absence--then WM will safeguard that information in accordance with other applicable laws, but such information is not subject to this Notice. Similarly, health information obtained by a non-health-related benefits plan that is part of the Waste Management Health and Welfare Benefits Plan, such as the Long-Term Disability Plan, is not protected under this Notice. This Notice does not apply in those types of situations because the health information is not received or created in connection with a WM Health Plan.

The remainder of this Notice generally describes our rules with respect to your PHI received or created by the Health Plans.

Plans’ Use and Disclosure of Your PHI

To protect the privacy of your PHI, the Health Plans not only guard the physical security of your PHI, but we also limit the way your PHI is used or disclosed to others. We may use or disclose your PHI in certain permissible ways described below. To the extent required by the Privacy Rules, we will limit the use and disclosure of your PHI to the minimum amount necessary to accomplish the intended purpose or task.

Treatment. We may disclose your PHI to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might

disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

Payment. We may use or disclose your PHI for Plan payment purposes, including the collection of premiums or determination of coverage and benefits. For example, we may use your PHI to reimburse you or your doctors or health care providers for covered treatments and services. We may also disclose PHI to another group health plan or health care provider for their payment purposes. For example, we may exchange your PHI with your spouse's health plan for coordination of benefits purposes.

Health Care Operations. We may use and disclose your PHI for Plan operations. These uses and disclosures are necessary to run the Plan. We may use medical information in connection with conducting quality assessment and improvement activities; enrollment, premium rating, and other activities relating to Plan coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. For example, we may use your claims data to alert you to an available case management program if you become pregnant or are diagnosed with diabetes or liver failure. We may also disclose your PHI to another health plan or health care provider who has a relationship with you for their operations activities if the disclosure is for quality assessment and improvement activities, to review the qualifications of health care professionals who provide care to you, or for fraud and abuse detection and prevention purposes.

Family and Friends. We may disclose PHI to a family member, friend, or other person involved in your health care if you are present and you do not object to the sharing of your PHI, or, if you are not present, in the event of an emergency.

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

Workers' Compensation. We may release your PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Reasons. We may disclose your PHI for public health actions, including (1) to a public health authority for the prevention or control of disease, injury or disability; (2) to a proper government or health authority to report child abuse or neglect; (3) to report reactions to medications or problems with products regulated by the Food and Drug Administration; (4) to notify individuals of recalls of medication or products they may be using; (5) to notify a person who may have been exposed to a communicable disease or who may be at risk for contracting or spreading a disease or condition; or (6) to report a suspected case of abuse, neglect or domestic violence, as permitted or required by applicable law.

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

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

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

Law Enforcement. We may disclose your PHI if asked to do so by a law enforcement official (1) in response to a court order, subpoena, warrant, summons or similar process; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement; (4) about a death that we believe may be the result of criminal conduct; and (5) about criminal conduct.

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

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

To Plan Sponsor. For the purpose of administering the Health Plan, we may disclose PHI to certain employees of WM. However, those employees will only use or disclose that information as described above, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.
Business Associates. We may enter into agreements with entities or individuals to provide services (for example, claims processing services) to one or more of the Health Plans. These service providers, called "business associates," may create, receive, have access to, use, and/or disclose (including to other business associates) PHI in conjunction with the services they provide to the Health Plan(s), provided we have obtained satisfactory written assurances that the business associates will comply with all applicable Privacy Rules with respect to such Health Plan(s).

In no event will we use or disclose PHI that is genetic information for underwriting purposes. In addition to rating and pricing a group insurance policy, this means the Health Plans may not use genetic information (including that requested or collected in a health risk assessment or wellness program) for setting deductibles or other cost sharing mechanisms, determining premiums or other contribution amounts, or applying preexisting condition exclusions.\

State law may further limit the permissible ways the Health Plans use or disclose your PHI. If an applicable state law imposes stricter restrictions on the Health Plans, we will comply with that state law.

Other Disclosures

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

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

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

Authorizations. Other uses or disclosures of your PHI not described above will only be made with your written authorization. This includes disclosures of PHI containing psychotherapy notes (except as necessary for the Health Plans' treatment, payment and healthcare operating purposes), for many marketing purposes and for any sale of your PHI, each as defined under HIPAA regulations. If you have given an authorization, you may revoke written authorization at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights

Federal law provides you with certain rights regarding your PHI. Parents of minor children and other individuals with legal authority to make health decisions for a Health Plan participant may exercise these rights on behalf of the participant, consistent with state law.

Right to request restrictions: You have the right to request a restriction or limitation on the Health Plans' use or disclosure of your PHI. For example, you may ask us to limit the scope of your PHI disclosures to a case manager who is assigned to you for monitoring a chronic condition. Because we use your PHI only as necessary to pay Health Plan benefits, to administer the Health Plans, and to comply with the law, it may not be possible to agree to your request. The law does not require the Health Plans to agree to your request for restriction. However, if we do agree to your requested restriction or limitation, we will honor the restriction until you agree to terminate the restriction or until we notify you that we are terminating the restriction on a going-forward basis.

To request restrictions on the use and disclosure of your PHI, you must complete and submit a written request on the "Request for Restrictions or Limitations Form" to the Benefits Center. When making such a request, you must specify: (1) the PHI you want to limit; (2) how you want the Health Plans to limit the use, disclosure, or both of that PHI; and (3) to whom you want the restrictions to apply.

Right to receive confidential communications: You have the right to request that the Health Plans communicate with you about your PHI at an alternative address or by alternative means if you believe that communication through normal business practices could endanger you. For example, you may request that the Health Plans contact you only at work and not at home.

To request a specific manner to receive confidential communications, you must complete and submit a written request on the "Request for Confidential Communications Form" to the Benefits Center. We will accommodate all reasonable requests if you clearly state that you are requesting the confidential communication because you feel that disclosure in another way could endanger your safety. You must make sure your request specifies how or where you wish to be contacted.

Right to inspect and copy your PHI: You have the right to inspect and copy your PHI that is contained in records that the Health Plans maintain for enrollment, payment, claims determination, or case or medical management activities, or that we use to make enrollment, coverage, or payment decisions about you. If PHI is maintained in an electronic health record, you shall have the right to obtain a copy of such PHI in an electronic format and may direct the Health Plan to transmit such copy directly to an entity or person, provided that you clearly and conspicuously communicate your instructions.

However, we will not give you access to PHI records created in anticipation of a civil, criminal, or administrative action or proceeding. We will also deny your request to inspect and copy your PHI if a licensed health care professional hired by the Health Plans has determined that giving you the requested access is reasonably likely to endanger the life or physical safety of you or another individual or to cause substantial harm to you or another individual, or that the record makes references to another person (other than a health care provider), and that the requested access would likely cause substantial harm to the other person.

In the unlikely event that your request to inspect or copy your PHI is denied, you may have that decision reviewed. A different licensed health care professional chosen by the Health Plans will review the request and denial, and we will comply with the health care professional's decision.

You may request to inspect or copy your PHI by completing the appropriate form available from the Benefits Center. We may charge you a fee to cover the costs of copying, mailing or other supplies directly associated with your request, although if a copy is in electronic form, the fee shall not be greater than the Plan's labor costs involved in responding to your request. You will be notified of any costs before you incur any expenses.

Right to amend your PHI: You have the right to request an amendment of your PHI if you believe the information the Health Plans have about you is incorrect or incomplete. You have this right as long as your PHI is maintained by the Health Plans. We will correct any mistakes if we created the PHI or if the person or entity that originally created the PHI is no longer available to make the amendment.

You may request amendments of your PHI by completing the appropriate form available from the Benefits Center. Be sure to include evidence to support your request because we cannot amend PHI that we believe to be accurate and complete.

Right to receive an accounting of disclosures of PHI: You have the right to request a list of certain disclosures of your PHI by the Health Plans. The accounting will not include (1) disclosures necessary for treatment, to determine proper payment of benefits or to operate the Health Plans, (2) disclosures we make to you, (3) disclosures permitted by your authorization, (4) disclosures to friends or family members made in your presence or because of an emergency, (5) disclosures for national security purposes or law enforcement, or (6) as part of a limited data set. Your first request for an accounting within a 12-month period will be free. We may charge you for costs associated with providing you additional accountings. We will notify you of the costs involved, and you may choose to withdraw or modify your request before you incur any expenses.

Accounting request forms are available from the Benefits Center. When making such a request, you must specify the time period for the accounting, which may not be longer than six (6) years prior to the date of the request, and the form (e.g., electronic, paper) in which you would like the accounting.

Right to receive notification of breaches. The Plan must notify you within 60 days of discovery of a breach. A breach occurs if unsecured PHI is acquired, used or disclosed in a manner that is impermissible under the Privacy Rules, unless there is a low probability that the PHI has been compromised.

Right to file a complaint: If you believe your rights have been violated, you should let us know immediately. We will take steps to remedy any violations of the Health Plans' privacy policy or of this Notice.

You may file a formal complaint with our Privacy Officer and/or with the United States Department of Health and Human Services at the addresses below. You should attach any documents or evidence that supports your belief that your privacy rights have been violated. We take your complaints very seriously. WM prohibits retaliation against any person for filing such a complaint. Complaints should be sent to:

Waste Management
1001 Fannin, Suite 4000
Houston, TX 77002

Attn: HIPAA Privacy Officer

phone: 800-964-3373
fax: 713-394-5190

You may also sent your complaint to: Office for Civil Rights U.S. Department of Health and Human Services 1301 Young Street, Suite 1169 Dallas, TX 75202 214-767-4056 FAX 214-767-0432 hhs.gov/ocr/hipaa/

Additional Information About This Notice

Changes to this Notice

The health plans reserve the right to change their privacy practices as described in this notice. These changes may affect the use and disclosure of your PHI already maintained by the health plans, as well as any of your PHI that the health plans may receive or create in the future. A copy of the current notice is available during normal business hours upon request to the Benefits Center, and on WMVisor. Additionally, we will provide you with the revised notice if there is a material revision to this notice.

No Guarantee of Employment

Nothing contained in this notice shall be construed as a contract of employment between WM and any employee, nor as a right of any employee to be continued in the employment of WM, nor as a limitation of the right of WM to discharge any of its employees, with or without cause.

No Change to Health Plans

This notice explains your privacy nights as a current or former participant in the WM health plans. The health plans are bound by the terms of this notice as they relate to the privacy of your PHI. However, this notice does not change any other rights or obligations you may have under the health plans. You should refer to the health plan documents for additional information regarding your health plan benefits.

Notes


WASTE MANAGEMENT