Summary Plan Description

Veolia North America Health and Welfare Benefits Plan

Summary Plan Description for Milwaukee Represented Employees

This Summary Plan Description summarizes the **self-funded benefits for Milwaukee represented employees** of the Veolia North America family of companies as of January 1, 2014. You should not rely on this information other than as a general summary of the self-funded benefits under the Veolia North America Health and Welfare Benefits Plan (the "Plan"). Fully-insured benefits under the Plan will be described in greater detail in the applicable certificate of insurance, which should be read in conjunction with this Summary Plan Description.

This handbook also serves as the official Summary Plan Description required by the Employee Retirement Income Security Act ("ERISA"). This Summary Plan Description is based on legal documents (such as plan documents and insurance contracts) currently in effect. As such, your rights are governed by the terms of these legal documents. Also, any questions concerning the Plan shall be determined in accordance with the terms of the relevant legal documents and not this Summary Plan Description.

While every effort has been made to give you correct and complete information about your benefits, in the event of any conflict or inconsistency between the Summary Plan Description and relevant legal documents, the terms of the legal documents will control.

In addition, no person has the authority to make any oral or written statement or representation of any kind which is legally binding upon the Company that alters the Plan document or any legal document maintained in conjunction with the Plan.

The Company intends to continue the benefit programs as described in this Summary Plan Description indefinitely but reserves the right, at its discretion, to change or even terminate all or any part of the benefits offered at any time and in any manner to the extent permitted by law. As a result, this Summary Plan Description is not a contract, nor is it a guarantee of your benefits.

If the Company does modify or terminate any of the benefit programs offered, a subsequent Summary Plan Description or Summaries of Material Modifications will be provided to advise you of any such modifications or termination, as required by ERISA.

At the end of this handbook, you will find contact information to obtain more information about your benefits, general administrative information regarding your ERISA rights and other important Plan information. In addition, a glossary is included that defines commonly used terms and phrases.

You should retain this handbook for future reference. If you have questions about your benefits, please contact the

Veolia Benefits Center at:

1.888.892.6564

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Participation

ELIGIBILITY

Your Eligibility

As a member of the AFSCME Local 366, Steamfitters 601, IBEW Local 494, Mach Local 66, IUOE Local 317, or the IBEW Local 781 Painters employed at Veolia's Milwaukee facilities, you are eligible for health and welfare benefits if you meet the requirements outlined in your collective bargaining agreement.

When Coverage Begins

Subject to certain exceptions and if you timely enroll for coverage, your coverage will begin as of the 1st day of the month following your hire date or date you became eligible, or, your hire date if hired on the first day of the month. Payroll deductions for your share of the coverage costs will begin as soon as administratively feasible after your coverage begins.

Preexisting Conditions

The medical program options do not restrict coverage for preexisting conditions. As such, coverage for medical conditions begins when your coverage under the medical program option begins.

Your Eligible Dependents

Subject to certain limitations described below, you may enroll your eligible dependents for medical, dental and vision coverage. You may also seek reimbursement for eligible expenses incurred for your eligible dependents under the Health Care FSA. The Dependent Care FSA and the Health Savings Account (HSA) have different dependent eligibility criteria. Please see the Flexible Spending Accounts section of this handbook for more information on who is an eligible dependent for purposes of receiving reimbursement of eligible expenses under the Dependent Care FSA, and see the Health Savings Account section for more information on who is an eligible dependent for purposes of the HSA. See the applicable certificates of coverage to see whether you might be eligible to purchase life insurance and supplemental accident insurance for your eligible dependents. Your eligible dependents include your:

- **Legal Spouse**, unless you are legally separated. "Spouse" means the individual to whom you are legally married through a governmental or religious ceremony or a common law marriage if recognized in your state of residence.

- **Domestic Partner,** is your same-gender partner who meets the following criteria: you are both at least 18 years old and live together in the same residence and have been in a committed relationship for at least 12 months. You must complete a Domestic Partner Affidavit in order cover your Domestic Partner. Please see "Domestic Partners: Tax Implications and Other Information" below for more details.

  Please note that while your domestic partner is generally eligible for benefits, your domestic partner is not eligible for coverage under the Health Care FSA or HSA, unless your domestic partner is a Section 152 (for purposes of the Health Care FSA) or Section 223 (for purposes of the HSA) dependent under the Internal Revenue Code.

  Dependent children whom you properly claim as dependents on your federal tax return to the end of the month in which they attain age 26, which can include:

  - ✓ Your natural children;
  - ✓ Your stepchildren or foster children living in your home;
  - ✓ Your domestic partner's children (see "Domestic Partners: Tax Implications and Other Information" below for tax-consequences of covering your domestic partner's non-dependent children);
  - ✓ Your legally adopted children (including children placed with you for adoption);
  - ✓ Children who live with you and for whom you are legal guardian; and
  - ✓ A child age 26 or older who, because of a mental or physical disability, lives with you and depends on you for financial support. The disability must have occurred before age 26. Proof of a mental or physical disability may be required to continue

coverage past age 26. Contact the Veolia Benefits Center for details. In this case, the child's coverage will continue only while he or she is disabled.

Proof of Dependent Status

You will be required to provide documentation as proof of your dependent's eligibility status. Appropriate documentation of your dependent's eligibility includes a marriage certificate, birth certificate, adoption papers, guardianship papers or disability. Failure to provide documentation within the requested timeframes will result in loss of coverage for your dependent.

Qualified Medical Child Support Order (QMCSO)

The Plan also provides health care 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. 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 the Company to cover a child as your dependent under the Plan for health care coverage. Federal law provides that a QMCSO must meet certain form and content requirements in order to be valid. If you have any questions or you would like to receive a copy of the written procedures for determining whether a QMCSO is valid, please contact the Veolia Benefits Center.

Dual Coverage

If your spouse or eligible dependent child also works for the Company and is eligible for health care coverage and the Health and Dependent Care FSAs, then he or she can enroll as an employee under his or her own coverage or as a dependent under your coverage. Note that dual coverage (enrolling as an employee as well as a dependent of an eligible employee) is not permitted.

If you and your spouse are both employed by the Company and eligible for health care coverage, only one of you may enroll your eligible dependent children.

Participation

ENROLLMENT

To receive coverage under the elective health and welfare benefits, you must timely enroll for those benefits. Your enrollment package will inform you of the specific methods of enrollment available and the specific time frames within which you can enroll. However, coverage under other benefits is provided automatically without any action required by you. The following chart shows which benefits require enrollment to receive coverage and which are provided automatically. **Please note that for the 2014 plan year, if you fail to make a benefit election, which includes waiving coverage, you will be defaulted into the**:

- HSA Silver medical option for employee-only coverage,
- Basic Life insurance;
- Basic Accidental Death and Dismemberment;
- Short Term Disability;
- Core Long Term Disability;
- Employee Assistance Program.

For later plan years, unless determined otherwise by the Plan Administrator, your elected coverage options will roll forward unless you make an affirmative election to change your options (with the exception of the FSAs).

Benefit Coverage	Enrollment Required (Elective Coverages)	Automatic Participation
Medical	X	X (for failure to make an election or waive coverage)
Dental	X	
Basic Vision	X	
Buy-Up Vision	X	
Health Care FSA	X	
Dependent Care FSA	X	
HSA	X	X (Company contributions for individual who elects HSA Gold medical coverage)
Employee Assistance Program		X
Disability		
▪ Short Term Disability*		X
▪ Core Long Term Disability		X
▪ Buy-Up Long Term Disability	X	
Life Insurance		
▪ Basic		X
▪ Supplemental	X	
▪ Dependent**	X	

Participation

Benefit Coverage	Enrollment Required (Elective Coverages)	Automatic Participation
Accident Insurance		
▪ Basic		X
▪ Supplemental	X	
▪ Dependent**	X	
Group Legal	X	
Business Travel Accident		X

*If you live in California, Hawaii, New Jersey, New York, Puerto Rico or Rhode Island, you will receive coverage under a state-mandated disability program. Please see the "Disability" section of this handbook for more details.
**You must enroll in supplemental life insurance in order to enroll your dependent under dependent life insurance (unless you cannot elect supplemental life insurance because you received the maximum coverage under the basic life insurance program).

There are three possible times at which you can enroll for coverage under your chosen benefits:

- Before your 45st day of eligible employment or the date you became eligible for benefits;
- During annual enrollment; and
- Within 31 days after you have a change in status or experience another event that allows you to make a mid-year election change.
- Within 60 days after you lose coverage under a Medicaid plan or a state children's health insurance program or become eligible for a premium subsidy under a State Child Health Plan.

Read on for more details of how to enroll and when your coverage becomes effective.

How to Enroll

Upon becoming initially eligible and before each annual enrollment, you will receive an enrollment package that will let you know how and when to enroll for coverage. If you need to make a mid-year election, please contact the Veolia Benefits Center for details on how to make any changes.

Coverage will become effective as described below depending on when you enroll. Payroll deductions for the cost of your elected coverage shall begin as soon as administratively feasible after coverage begins and will end effective as of the last day of your eligibility.

Except for elections under the Health and Dependent Care FSAs, the elections you make for all other coverages - whether upon your initial eligibility, during annual enrollment or, if permitted, during the year - will stay in effect until you change them upon an event permitting a mid-year change in elections or during a subsequent annual enrollment period. This means your elected coverage will continue from Plan year to Plan year without further action on your part. It also means that if you do not have coverage under a Program for one Plan year, you will not have coverage under that program for a subsequent Plan year, unless you enroll for coverage upon an event permitting mid-year enrollment or at annual enrollment. If the Company decides to conduct a positive enrollment period during which you would be required to make an affirmative election for each program in which you wish to participate (even if you are currently enrolled in that program), you will be notified in your enrollment package that you receive in connection with annual enrollment.

In any case, for the Health and Dependent Care FSAs, you will need to make an election for each Plan year in which you wish to participate in one or both of these programs. Your elections for the FSAs will not continue from Plan year to Plan year.

Initial Eligibility

If you are a new Company employee eligible to elect coverage or were previously an ineligible employee who becomes an eligible employee, you can enroll for coverage under your chosen benefits any time before your 45th day of eligible employment or the date you became eligible for benefits. Your enrollment materials will inform you of the current cost of coverage and what

information is needed to complete enrollment. See "When Coverage Begins" for information on the effective date of coverage.

If you do not enroll for coverage before the 45th day of eligible employment, you will have only Company-provided coverage (with the exception of vision) and employee-only HSA Silver medical coverage. You will not have the following coverage: dental, vision, Health or Dependent Care FSAs, HSA, Long Term Disability buy-up, supplemental and dependent life insurance, voluntary accident insurance and voluntary legal. As a result, your next opportunity to elect such coverage will be annual enrollment, unless a change in status or other event occurs that allows you to enroll for coverage before annual enrollment.

However, you will be eligible for the employee assistance program if you meet the eligibility requirements outlined in your collective bargaining agreement.

Annual Enrollment

Each fall, you may elect coverage under any of the benefit programs 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.

If you are on an unpaid leave of absence and did not continue your coverage during your unpaid leave of absence, but make new elections during annual enrollment, the effective date of all your newly elected coverage will be delayed until you return to work as an eligible employee. (See "Changing Coverage During the Year" below for further details.)

Before the annual enrollment period begins, you will receive a packet of information that is designed to help you with your annual enrollment elections. The packet describes the enrollment procedures, the coverage options available for the upcoming Plan year, your cost for each option, the maximum contribution under the Health and Dependent Care FSAs, and any changes to the available coverage since the last annual enrollment period. Your enrollment materials contain important tips on how to enroll. Be sure to read the information carefully.

During annual enrollment, you have the opportunity to:

- With respect to health care coverage, switch from one medical option to another (if more than one option is offered in your location), add or drop dependents, or decline or add medical, dental, vision, supplemental accident or group legal coverage for the next calendar year.
- With respect to the Health and Dependent Care FSAs and HSAs, enroll for coverage and authorize the amount you want to deduct from your pay on a pre-tax basis, subject to certain maximums.
- Certain other restrictions may apply. Please see the certificates of coverage for the fully-insured benefits for further details on any EOI requirements or other limitations on the availability of disability, life and accident coverage.

Special Circumstances: Reemployment

If you leave the Company and subsequently return to the Company, depending on the time that elapses between your termination date and the date on which you are rehired, you may or may not be eligible to make new elections.

- If you are rehired within 30 days of your termination, the coverage in effect immediately before your termination will be reinstated.
- If you are rehired 30 or more days after your termination, you have a choice as to whether or not to resume coverage and you may make new coverage elections.

Changing Coverage During the Year

Because of the tax advantages that apply to the Plan when you pay for coverage on a pre-tax basis, federal rules and regulations restrict your ability to change your benefits and change your covered dependents once elections become effective. These rules and regulations govern the types of changes that you may make during the Plan year. In general, once you enroll for (or decline) coverage, your benefit elections and covered dependents stay in effect until you change them at annual enrollment.

However, under certain circumstances, you may enroll, or add or remove eligible dependents during the Plan year. Except as otherwise specifically permitted, you cannot change from one coverage option to another. If you experience an event permitting a mid-year change, you may make changes to any of your elections (whether paid on a pre-tax or after-tax basis), subject to certain exceptions and limitations explained below. However, any changes must be consistent with the event.

If you are contributing to an HSA, you may change your coverage election at any time.

An overview of the categories of events permitting you to make election changes to some or all of your health and welfare coverage are as follows:

- **QMCSO -** The Plan Administrator receives a Qualified Medical Child Support Order (QMCSO) requiring you to enroll a dependent child for health care coverage, which may include the Health Care FSA;
- **Medicare or Medicaid Entitlement -** You or your dependent enroll in or lose coverage under Medicare or Medicaid;
- **Significant Cost or Coverage Changes -** The cost of the coverage significantly increases or decreases, or coverage is significantly curtailed or lost;
- **State Children's Health Insurance Plans –** You can enroll your dependent mid-year if your dependent loses eligibility under a State children's health insurance plan;
- **HIPAA Special Enrollment -** You qualify for a special enrollment during the year under the Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- **Unpaid FMLA Leave -** You can cease coverage when you go on unpaid FMLA leave;
- **Domestic Partners -** If your domestic partner is not your dependent (as described in "Domestic Partners: Tax Implications and Other Information"), his or her coverage cannot be provided on a pre-tax basis; so you may add or drop coverage for him or her on an after-tax basis consistent with the change in your domestic partner status (but only in accordance with the election change rules that would otherwise apply for spouses); or
- **Change In Status -** You experience a "change in status" – as described in this section – that affects your or your dependents' eligibility for health and welfare coverage.

Each of these events is explained in more detail below. Please note that these events permit you to change your elections after the elections take effect during a Plan year.

In contrast, if you enroll for coverage during the annual enrollment period, but your spouse's annual enrollment period occurs after the Company's (but in the same year), you may make election changes that correspond with your spouse's changes without regard to the rules on changing coverage mid-year described here. *For example, assume you make your election coverage during the Company's annual enrollment period that takes place in November. A month later in December, your spouse's employer conducts its annual enrollment period. If you want to make election changes under the Company plan that correspond with your spouse's elections, you may do so before the Plan year starts. Once the Plan year starts and your elections take effect, you will be permitted to make changes only pursuant to the rules described in this section.*

Election Period for Changing Coverage and Effective Date of Coverage

If you experience an event permitting you to change any of your health and welfare coverage, you must notify the Veolia Benefits Center and make your election changes within 31 days after the event. If timely made, coverage changes made due to a mid-year event are generally effective on the date you notify the Veolia Benefits Center following a timely election change due to the event. Three exceptions are:

- For enrollment of a child pursuant to a QMCSO, coverage will be effective immediately after the Plan Administrator determines the QMCSO is valid,
- For HIPAA special enrollment of a child as a result of birth, adoption or placement for adoption, coverage will be effective as of the date on which you acquired the child, and

- For coverage that require you or your dependent, as applicable, to satisfy EOI, coverage will be effective on the later of the first day of the month following a timely election change or the day on which the insurance company approves your EOI.

If you do not make a timely election, you will not be able to make a mid-year election and will have to wait until annual enrollment to make any election changes. However, if you are enrolled in a medical option and your coverage level in effect before your special enrollment event is Employee + Family, you may add a new dependent at any time. In this case, coverage will become effective on the date you notify the Veolia Benefits Center.

For example, assume you have "Employee Only" coverage in effect under the medical program. On July 12, you get married and want to change your medical coverage level from Employee Only to Employee + Spouse. You must make your election change no later than August 11. If you timely make your election, your spouse will have medical coverage beginning the date you notify the Veolia Benefits Center. If you do not make a timely election (e.g. you submit your election on or after August 12), your spouse will not have medical coverage through the Plan. In this case, you will have to wait until the annual enrollment period to enroll your spouse.

In addition, you will be required to provide proof of your change in status or other event, if appropriate. If proof is requested and you do not provide proof, you cannot change your coverage until the next annual enrollment, unless you once again meet one of the events for a mid-year change. The Plan Administrator reserves the right to require, at any time, appropriate documentation of your change in status or other event.

Event 1: Enrollment Pursuant to a QMCSO

You, a custodial parent or a state agency may enroll your dependent child in health care coverage, including the Health Care FSA, pursuant to the terms of a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, which is determined to be a Qualified Medical Child Support Order (QMCSO). Alternatively, coverage for a dependent child may be revoked if the QMCSO requires the spouse, former spouse or another individual to provide coverage for the child. Only the child who is eligible for coverage pursuant to a QMCSO may be enrolled for or dropped from coverage.

A dependent child can be enrolled for health care coverage pursuant to a 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. Coverage will be effective immediately following the Plan Administrator's determination that the order is valid.

Event 2: Medicare or Medicaid Entitlement

If you, your spouse or other dependent becomes entitled to Medicare or Medicaid coverage, you can drop Company coverage for yourself or that individual, as the case may be. In contrast, if you, your spouse or other dependent lose Medicare or Medicaid coverage, you may enroll for Company coverage for yourself or that individual, as the case may be.

Event 3: State Children's Health Insurance Plans

If your dependent loses coverage under a state children's health insurance program and you notify the Plan Administrator within 60 days, you can add Company coverage for that individual.

Event 4: Significant Cost or Coverage Changes

A number of events come under this category, and are described below. Keep in mind that the occurrence of any of the described events will not permit any changes to your Health Care FSA.

- The cost of coverage for a benefit option significantly increases or significantly decreases during the Plan year (including if the significant cost change occurs under your spouse's employer plan)

  The Plan Administrator, in its discretion, makes a determination whether an increase or decrease is significant triggering a right to make mid-year election changes. Any insignificant increases or decreases, as determined by the Plan Administrator, in the cost of coverage will be made automatically.

If cost for a coverage option in which you do not participate significantly decreases, you can make an election to participate in that coverage option. In contrast, if the cost for your elected coverage option significantly increases, you can select another coverage option providing similar coverage (e.g. change from the medical PPO option to EPO option). If no option provides similar coverage, then you can drop coverage.

Keep in mind that if you participate in the Dependent Care FSA, a change can be made only as a result of this event if the cost change is imposed by a dependent care provider who is not your relative.

- An event occurs that significantly curtails coverage or causes you to lose coverage under your current coverage option

  A significant curtailment of coverage can include such things as a significant increase in the deductible, the copay or coinsurance amounts, and results in an overall reduction in coverage. In addition, the Plan Administrator may, in its discretion, treat a substantial decrease in participating physicians from a medical network as a significant curtailment of coverage. However, if you choose to participate in a medical option and your doctor leaves the network, your coverage is not considered significantly curtailed for purposes of this event.

  An event that may cause you to lose coverage can include such things as elimination of a coverage option.

  These events allow you to change your coverage option to another coverage option providing similar coverage. If no similar coverage is available, then you may revoke coverage.

- A coverage option is added or significantly improved during the Plan year and you are eligible for it.

  In this event, even if you did not enroll for coverage, you can elect coverage under the new or significantly improved option.

- You or your dependent loses coverage under any group health coverage sponsored by a governmental or educational institution.

  This event allows you or your dependent to enroll for coverage. Note that if you gain eligibility for group health coverage sponsored by a governmental or educational institution, you may not drop your Company coverage.

- The change corresponds with a change made by you or your dependent under another employer plan in the following circumstances:

  ✓ If the annual enrollment period under the other employer plan occurs at a different time of year than Company's annual enrollment and the other employer plan has a period of coverage that is different than the calendar year period of coverage provided under the Company programs.

  For example, you elected medical coverage during Company's annual enrollment held in November. Your spouse's employer conducts annual enrollment in the following February for a 12-month Plan year that begins March 1. In this case, you can drop your Company medical coverage if your spouse wants to enroll you as dependent in her employer's health plan; or

  ✓ If the other employer plan allows you or your dependent to change elections due to the reasons described above (change in status, special enrollment, QMCSO, Medicare or Medicaid entitlement and significant cost or coverage changes).

Event 5: HIPAA Special Enrollment

Under HIPAA, you have the right to enroll yourself and your dependents for medical coverage, even if you were not previously enrolled, within 31 days after the following special enrollment events:

- You declined medical coverage because you or your dependent had other coverage and the other coverage ends because:

  ✓ You or your dependent are no longer eligible for such coverage (whether such coverage was provided through another employer, private insurance or otherwise);

- ✓ You or your dependents exhaust COBRA coverage under another employer's group health plan (other than due to a failure to pay contributions or cause); or

- ✓ Employer contributions toward the other group health plan coverage terminate.

If you timely enroll, coverage will take effect the day you timely notify the Veolia Benefits Center.

- You acquire a dependent as a result of a marriage, birth, adoption or placement for adoption. In the case of birth, adoption or placement for adoption, if you timely enroll, coverage will take effect on the date you acquired the new dependent. In the case of marriage, if you timely enroll, coverage will take effect on the first day of the month following enrollment.

If you do not request the change within 31 days of your special enrollment event, you lose special enrollment rights for that event. However, if you are enrolled in a medical option and your coverage level in effect before your special enrollment event is Employee + Family, you may add a new dependent at any time. In this case, coverage will become effective on the date you notify the Veolia Benefits Center.

Please note these special enrollment rights apply only to changes in medical coverage and permit you to enroll only yourself and your affected dependents. They do not apply to any other changes in benefit coverage, such as dental or vision coverage or the Health Care FSA.

Event 6: Change in Status

You can change your health and welfare coverage during the year if a change in status occurs that affects eligibility for coverage under the Plan or under another employer's group health plan (such as the plan of a dependent's employer). A change in status is any of the following:

- You get married, establish a domestic partnership, divorced, legally separated or you have your marriage annulled;

- Your spouse/domestic partner, or dependent dies;

- Your dependent becomes eligible for coverage or ineligible for coverage (e.g., he or she reaches the eligibility age limit);

- You acquire an eligible dependent child;

- You, your spouse/domestic partner, or other dependent experiences a change in employment status. Changes in employment status include any of the following:

  - ✓ Start or end of employment (See "Special Circumstances: Reemployment" above for unique rules in the case of reemployment);

  - ✓ Begin an unpaid leave of absence or a paid leave of absence becomes unpaid (details regarding coverage during a leave of absence are provided below);

  - ✓ Change in work sites and your previous coverage is no longer available (*for example, you move outside your EPO's service area*);

  - ✓ Change in hours of employment to become eligible or vice versa;

  - ✓ Any other change in employment that leads to a loss of or gain in eligibility for coverage; or

- Your home residence changes and your previous coverage option is no longer available (*for example, you move outside your EPO's service area*).

Consistency Rule

For change in status elections under a health care program, any election change you make must affect eligibility under that program. In addition, regardless of what event you experience, any election change you make to any of your coverage must be because of and consistent with the event.

The Plan Administrator, in its sole discretion, shall determine whether an event permits an election change and, if so, whether the election change is consistent with the event, in accordance with rules established by the IRS.

Participation

Important Notes Regarding Changes in Status:

- ✓ You can make appropriate changes to your Health Care FSA contributions. However, please note that if you experience a change in status that allows you to decrease your Health FSA contributions, you cannot make an election change that will result in decreasing your annual contribution amount below what you have already contributed through the date the change will become effective. *For example, if you elect an annual contribution amount of $1,000 and have contributed $600, you cannot elect to decrease your annual contribution amount to $500*.

- ✓ A newborn child will be automatically covered under the medical programs described in this handbook while the mother is hospitalized for the birth of the child. Following the mother's discharge from the hospital, you must notify the Veolia Benefits Center to enroll the newborn child no later than 31 days following the child's birth.

- ✓ For changes in status resulting in either you or a dependent becoming ineligible, note that coverage automatically ends as of the event resulting in your or your dependent's ineligibility (with the exception of a dependent aging out, in which case coverage will continue through the end of the month in which the dependent reaches the limiting age). A timely-made mid-year election change will stop the premium deduction that relates to the cost of coverage.

- ✓ Also, please note that if you become divorced or legally separated or a dependent child is no longer eligible for coverage, your spouse or child, as the case may be, will lose health care coverage under the Plan at the end of the calendar month in which the event occurs. The individual losing health care coverage will have the right to continue coverage under COBRA. To exercise these COBRA rights, the individual (or you, on the individual's behalf) must notify the Veolia Benefits Center within 60 days of the loss of coverage. Please see "Health Care Continuation Rights (COBRA)" later in this section for more information on COBRA.

Coverage During Leaves of Absences

As noted above, the beginning of an unpaid leave of absence is a change in status permitting election changes. To assist you in determining whether your leave is paid or unpaid triggering your right to make an election change, the following chart identifies which leaves will be considered paid and unpaid.

Paid LOA*	Unpaid LOA
▪ FMLA plus paid-time off ▪ Sick leave ▪ Bereavement ▪ Jury duty ▪ Involuntary military leave with pay differential**	▪ FMLA and no other income source ▪ Non-FMLA medical leave without Company salary continuation ▪ Personal leave of absence and no other income source ▪ Voluntary military leave**

*If any of these paid LOAs become unpaid, election changes may be made.

**Continuation of elective disability, life insurance and AD&D coverage are subject to the terms of insurance policies and Company's military leave policy, and may not continue during a military leave. Please contact the Veolia Benefits Center for details.

In the event you qualify for an unpaid leave of absence under Company's leave of absence policy (like a FMLA leave or personal leave), the following describes how your coverage may be impacted

during your leave of absence and what happens when you return from a leave of absence.

- Continue to Participate in All or Some of Your Coverages

  The coverage in effect when you begin your leave of absence will automatically continue during your leave of absence. So, you will not have to complete any election forms if you want to continue your coverage during your leave, but you must still make your required contributions by paying the contributions over the course of your leave.

  During your leave of absence, you will be required to pay for your coverage with after-tax dollars. You will need to send a check to the Company (or applicable third-party administrator or insurance company) at the beginning of each month to pay for your coverage.

  Rules Regarding Failure to Pay for Coverage During Leaves of Absence:

  If you return from a leave of absence and payment for coverage received during your leave of absence is not received after the 30-day grace period for the second billing period expires, coverage will terminate retroactively to the beginning of the period for which payment was not made. If coverage terminates and you incur services during that period, your services will not be covered.

  For example, you take a three month unpaid leave of absence that begins on June 1. You pay for coverage provided during the month of June. But, you do not pay for coverage provided in July or August. In this circumstance, your coverage will terminate effective as of July 1. Note that if your health care coverage is terminated due to your failure to pay the required contributions, you will not have any COBRA rights.

- Terminate All or Some of Your Coverages

  You may choose to terminate your participation in any of your coverage. To do so, you must make a timely election within 31 days of the beginning of your approved leave of absence by notifying the Veolia Benefits Center. If you do not terminate your coverage during this election period, you cannot change your benefit elections until the next annual enrollment period unless you experience another event permitting a mid-year election change. In such circumstance, coverage will continue and you will be required to continue paying for coverage through the course of your leave of absence, as described above.

- Return from Leave of Absence in Same Plan Year

  If you terminate all or some of your coverage when you begin your leave of absence and you return from your leave in the same Plan year as when your leave began, those coverage will be reinstated upon your return. Except as described below for the Health and Dependent Care FSAs, coverage will be reinstated at the same level.

  With respect to the Health and Dependent Care FSAs, if you choose not to continue coverage during your leave of absence, your coverage will also be reinstated upon your return, but you can choose the level at which deductions will resume. In particular, for the FSAs, you can choose to:

  - ✓ reinstate your per pay period deduction amount, or
  - ✓ adjust your per pay period deduction to meet your elected annual contribution.

  In either case, you will not be able to receive reimbursement from your FSAs for eligible expenses incurred during your leave of absence.

  For example, assume you elect a total of $1,300 to be contributed to your Health Care FSA. Assuming 26 pay periods in a year, this means your pay will be reduced, on a pre-tax basis, by $50 each pay period. Further assume you take a leave of absence starting July 1 and choose not to continue your Health Care FSA contributions during your leave. Before your leave, you would have contributed $650 towards your annual contribution over 13 pay periods. When you return from your leave, let's assume there will be another 10 pay periods over which deductions will be taken.

Using this example, if you choose to reinstate your original pay period deduction, then your $50 per pay period deduction will resume. In this case, your annual elected amount will be adjusted downward to $1,150 to account for the leave during which you did not participate in the Health Care FSA.

In contrast, if you choose to adjust your per pay period deduction to meet your elected annual contribution, then upon your return from leave, your deduction amount will be adjusted from $50 per pay period to $65 per pay period, determined as follows. When you return from your leave, 10 payroll periods remain over which $650 must be deducted to meet your elected annual contribution of $1,300 (as you already contributed $650 before your leave). So, upon your return from leave, your deduction amount will be adjusted to $65 per pay period ($650/10) to make up for the pay periods during your leave that you did not make contributions to the Health Care FSA. In this example, even though your per pay period deduction is increased, you will meet your elected annual contribution of $1,300.

- Annual Enrollment During a Leave of Absence and Return from a Leave of Absence in Different Plan Year

  If the annual enrollment period occurs while you are on a leave of absence, you will be sent an annual enrollment package and may make election decisions for the upcoming Plan year. To ensure you receive your annual enrollment package, please give your contact information to the Veolia Benefits Center so that it has the most updated information for you during your leave.

  If you continue coverage during your unpaid leave of absence, then any election changes you make during annual enrollment will take effect as if you were actively at work (except new elections for disability, life and accident coverage, which are delayed until you return to work as an eligible employee). If you do not make any election changes, your elections in effect will continue (except for the Health and Dependent Care FSAs and your HSA).

  If you do not continue coverage during your unpaid leave of absence and make elections during annual enrollment, those elections will not take effect until you return from your unpaid leave of absence.

  If you are on an unpaid leave of absence and do not make new elections during annual enrollment, you will be given 31 days to make new election choices when you return to work, whether or not you continued your coverage during your unpaid leave of absence.

  If you do not make any elections during either annual enrollment or the 31 day election period upon your return, the coverage in effect during your leave will be continued (except for the Health and Dependent Care FSAs and your HSA). If you terminated coverage during your leave of absence and do not make any elections during either of these election periods, you will not have any elective coverage upon your return. In this case, you may have only the Company-provided coverage, depending on which coverage you terminated before your leave of absence.

- Other Mid-Year Events

  Keep in mind that if you also experience another event permitting a mid-year change in coverage during your leave, such as a change in status and/or a HIPAA special enrollment event (discussed below), you may change your coverage in accordance with the rules for that event.

Summary of Events

The following chart illustrates the types of election changes under the elective health and welfare programs that would be considered consistent with some of the events described above. The chart is not an exhaustive list, but is simply meant to give you an idea of the types of election changes that could be made. In addition, enrollment in the disability and life coverage may be subject to additional EOI requirements. As noted above, the Plan Administrator, in its discretion, has the authority to determine whether an election change is permitted.

Participation

	Medical, Dental, Vision	Health Care FSA	Dependent Care FSA	Supplemental and Dependent Life Insurance and Accident Insurances and Buy-UP Long Term Disability
Marriage*	▪ Enroll spouse and/or child for coverage ▪ Change coverage tier ▪ Revoke coverage if spouse adds you under his or her employer plan	▪ Enroll or increase election (Health Care FSA) ▪ Revoke or decrease election if you become eligible under a spouse's plan (Health Care FSA)	▪ Enroll/increase election if the spouse has a qualifying dependent ▪ Revoke/decrease election if eligible under the spouse's plan	▪ Enroll or increase coverage ▪ Revoke/decrease coverage
Birth/Adoption/Legal Guardianship	▪ Enroll spouse and/or child for coverage ▪ Change coverage tier ▪ Revoke coverage if spouse adds you/your children under his or her employer plan	▪ Enroll or increase election (Health Care FSA) ▪ Revoke or decrease election if you become eligible under a spouse's plan (Health Care FSA)	▪ Enroll/increase election	▪ Enroll or increase coverage ▪ Revoke/decrease coverage
Divorce*	▪ Enroll children who lose coverage under spouse's plan ▪ Change coverage tier ▪ Drop spouse from coverage	▪ Decrease election to reflect loss of spouse's eligibility ▪ Increase election where coverage lost under spouse's plan	▪ Enroll/increase election ▪ Revoke/decrease election	▪ Enroll or increase coverage ▪ Revoke/decrease coverage
Loss of Other Health Coverage (HIPAA Special Enrollment)	▪ Enroll spouse and/or child for coverage ▪ Change coverage tier	▪ No change permitted	▪ Enroll/increase election	▪ Enroll or increase coverage ▪ Revoke/decrease coverage

Participation

Death of a Spouse or Child	▪ Enroll spouse/children who lose coverage under another plan ▪ Change coverage tier ▪ Drop coverage for person who died	▪ Decrease election to reflect loss of spouse's eligibility ▪ Increase election where coverage lost under spouse's plan	▪ Enroll/increase election	▪ Enroll or increase coverage ▪ Revoke/decrease coverage
Paid Leave of Absence	No change permitted	No change permitted	No change permitted	No change permitted
Unpaid Leave of Absence	▪ Drop coverage ▪ Continue coverage if contributions are paid (in advance or regularly during leave)	▪ Drop coverage ▪ Continue coverage if contributions are paid (in advance or regularly during leave)	▪ Drop coverage ▪ Continue coverage if contributions are paid (in advance or regularly during leave)	▪ Drop coverage ▪ Continue coverage if contributions are paid (in advance or regularly during leave)

*Rules may vary slightly for domestic partners. Contact the Plan administrator for additional details.

Participation

COST OF COVERAGE

Payment for Coverage

The cost of the benefit coverage under the Plan will vary from year to year due to changing health care costs and inflation. During each annual enrollment period, you will receive the current costs of coverage under each benefit offered (unless the coverage is automatically provided at Company's expense). You may contact the Veolia Benefits Center for current contribution rates.

The chart below highlights who pays for the benefit coverage and on what basis they are paid. Depending on the benefit chosen, either Veolia North America or you may pay for all of the coverage, or you may share the cost of the coverage with Veolia North America. In addition, it shows you how you pay for each benefit coverage -- on a pre-tax or after-tax basis.

Coverage	Company Pays	You Pay	You and Company Pay	You Pay Pre- or After-Tax
Medical			X	Pre-Tax***
Dental			X	Pre-Tax***
Basic Vision	X			N/A
Voluntary Vision			X	Pre-Tax***
Health Care FSA		X		Pre-Tax*
Dependent Care FSA		X		Pre-Tax*
HSA			X	Pre-Tax*
Employee Assistance Program	X			N/A
Disability				
▪ Short Term Disability	X			N/A
▪ Core Long Term Disability	X			N/A
▪ Buy-Up Long Term Disability		X		After-Tax
Life Insurance				
▪ Basic**	X			N/A
▪ Supplemental		X		After-Tax
▪ Dependent		X		After-Tax
Accident Insurance				
▪ Basic	X			N/A
▪ Supplemental		X		After-Tax
▪ Dependent		X		After-Tax

Participation

Coverage	Company Pays	You Pay	You and Company Pay	You Pay Pre- or After-Tax
Business Travel Accident	X			N/A
Voluntary Group Legal		X		After-Tax

* You may not seek reimbursement through your HSA or health care FSA for a domestic partner who is not your dependent for purposes of Section 152 of the Internal Revenue Code. For the dependent care FSA, child care expenses are only reimbursable for domestic partner's child if the child is your dependent under Section 152 of the Internal Revenue Code.

**Your Veolia-paid life insurance benefits are tax-free if your coverage does not exceed $50,000. But, if your coverage exceeds $50,000, you are taxed on the cost of the coverage over $50,000, which is added to your Form W-2 for tax purposes.

***If you elect to cover your domestic partner, coverage for your domestic partner will be paid on a pre-tax basis, but the additional cost that you pay for your domestic partner coverage will be imputed to you as income if your domestic partner is not a dependent for purposes of Section 152 of the Internal Revenue Code. See "Domestic Partners: Tax Implications and Other Information" below for more details.

Pre-Tax vs. After-Tax

As shown in the chart above, you pay for coverage under certain benefits 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, making more of your paycheck available for you and your family. However, when determining your coverage levels for other benefits (e.g. your coverage level of basic life insurance) under the Plan, your income is not reduced by the cost of coverage paid on a pre-tax basis, so you get the benefit of a higher coverage level. All of this means that you pay for the benefits without a tax cost. For many, this tax advantage may be significant.

You pay for coverage under other benefits on an after-tax basis. This means that you pay for the cost of coverage 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.

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. If you earn less than the Social Security "taxable wage base" ($117,000 for 2014) after making contributions to the Plan, your pre-tax contributions to the Plan will lower the portion of your wages that is subject to Social Security taxes. As a result, your Social Security taxes will be lower, which may, in turn, cause your Social Security benefits to be slightly lower when you retire or if you become disabled. The amount of benefit reduction will depend on the amount of your pre-tax contributions and how long you participate in the Plan before you retire. In contrast, the reduction may be 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. As always, you should consult a financial advisor about the effects of your participation in the Plan.

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.

Remember, however, that income tax laws change frequently, and these changes affect different individuals in different ways. Therefore, Company cannot assure you that it will be to your advantage to participate in the Plan.

Domestic Partners: Tax Implications and Other Information

If you choose to cover your domestic partner as a dependent under your health care coverage, there are important tax implications related to the cost of coverage of which you should be aware. While Company permits a domestic partner to be covered as an eligible dependent, the federal government has not changed its definition of dependent under Internal Revenue Code Section 152 to recognize domestic partners. Most domestic partners do not qualify under Section 152 as dependents for income tax purposes.

To be a Section 152 dependent, your domestic partner must live in your home, be in a relationship with you that does not violate local law, be a citizen of the U.S. or a resident of the U.S. or a country contiguous to the U.S. and, for your taxable year, be over 50% supported by you.

If your domestic partner does not qualify as your legal dependent, you will be shown to have paid for your domestic partner's health care coverage on a pre-tax basis. However, Company will impute income to you in the amount of the pre-tax cost of coverage for your domestic partner plus Company will include in your reportable income the value of any medical, dental and vision insurance coverage that Company provides for such domestic partner. You will then be taxed on the amount reported. If you believe that your domestic partner meets the requirements to be your Section 152 dependent such that income should not be imputed to you, please submit to the Veolia Benefits Center a completed Affidavit of "Dependency" for Tax Purposes. Copies of the Affidavit may be obtained from the Veolia Benefits Center.

Therefore, before enrolling your domestic partner for health care coverage, you should check with your tax advisor for assistance in determining the precise manner in which these additional benefits affect your personal income situation.

Please note that with respect to your domestic partner, they must qualify as your Section 152 dependents to be eligible for health care coverage. Therefore, if your domestic partner is your Section 152 dependents, their cost of coverage will not be reportable as income to you. Please confirm your domestic partner's dependent status with your tax advisor.

COORDINATION OF BENEFITS

Your health care coverage coordinates 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 Plan Administrator if you are covered by other plans.

In contrast, if you are eligible for Short Term Disability or Long Term Disability benefits, the amount of your disability benefit paid from the Plan may be reduced by amounts payable from other sources in the event of your disability. See the certificates of coverage for the disability benefits for more information. **Important note: The Plan does not coordinate benefits for prescription drug coverage. If your spouse, domestic partner or dependent has primary prescription drug coverage through another plan, this Plan will not pay for your spouse, domestic partner or dependent's prescriptions.**

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; and
- Automobile insurance plans.

Your health care coverage 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 Company's Plan.

How Coordination with Other Group Plans Works

If you are covered by more than one group plan, one plan is primary. The primary plan pays benefits first without considering the other plans. Then the other plans pay benefits.

Participation

If your Veolia health care coverage is your primary plan, the Plan pays benefits up to the limits described in this handbook. When the Veolia coverage is the secondary plan, it figures its regular benefit as if it were primary, subtracts from that amount the primary plan's benefits and then pays the difference. Therefore, the benefits payable from the Veolia Plan may be reduced so that the benefits paid by all plans do not exceed 100% of the allowable expenses under the Veolia Plan. Further, if the Veolia Plan is secondary, its payments are limited to a maximum of what it would have paid if it were the only plan providing coverage. When your Veolia Plan is the secondary plan, any allowable expenses that would have counted toward satisfying your deductible and/or annual out-of-pocket maximum will be applied to the Veolia Plan.

For example, suppose your spouse is covered by his or her employer's plan and as a dependent under the Veolia Plan. The Veolia Plan is the secondary payer for your spouse. Let's also assume that your spouse paid the deductible for his or her plan, has $100 in eligible dental expenses, the other dental plan pays 70% (or $70 of these eligible expenses), and the Veolia Plan pays 80% (or $80) of these eligible expenses. Here's how the benefits are determined:

Eligible expense	$100
Spouse's dental plan pays first	$ 70 (70%)
Veolia plan pays second	$ 10 ($80 - $70)
Total benefit paid from both plans	$ 80

If your spouse was covered only by the Veolia Plan, the Veolia Plan would have paid an $80 benefit. However, because the other group plan pays 70% ($70) first, the Veolia plan would only pay the remaining amount necessary to bring the total benefit up to the Veolia plan benefit level of 80% ($80).

If the other plan already pays the same or higher benefits, the Veolia Plan pays no benefits.

Determining the Order of Payment

If you have health care coverage under a group health plan or Medicare in addition to your Veolia health care coverage, National Association of Insurance Commissioners (NAIC) rules indicate which plan pays first. These rules prioritize how benefit payments are coordinated to avoid duplication of benefits.

Following is a summary of the NAIC rules. The primary plan pays before a secondary plan. The first rule that applies to you will determine which plan is primary and which is secondary.

- **Rule 1:** *No Coordination of Benefits Provisions*. If one plan does not have a coordination of benefits provision, then it is the primary plan, while the plan with the coordination provision is the secondary plan.

- **Rule 2:** *Dependent/Non-dependent.* A plan covering a person as an employee is primary over a plan covering that person as a dependent.

  Exception: There is an exception for Medicare beneficiaries whose Medicare coverage is secondary by law. If you are a Medicare beneficiary, please call the Veolia Benefits Center for more information.

- **Rule 3:** *Child of Parents NOT Separated or Divorced.* In this case, the Birthday Rule applies. Under the Birthday Rule, benefits are paid first by the plan of the parent whose birthday is earlier in the year. If, by chance, both parents have the same birth date, then the plan of the parent who has been covered longer pays first.

  For example, if Mom was born on March 21 and Dad was born on May 10, then Mom's plan is considered primary, regardless of the actual year in which they were born.

- **Rule 4:** *Child of Separated or Divorced Parents.* If a court order specifies that one of the parents is responsible for the child's health care coverage, the plan of that parent is primary.

  If the court decree awards joint custody without allocation responsibility for the child's health care coverage, the Birthday Rule

determines which parent's plan is primary. If the parents do not share custody and no court order allocates responsibility for the child's health coverage, the plan of the custodial parent pays first, the plan of the spouse or domestic partner of the custodial parent (if any) pays second, the plan of the non-custodial parent pays next, and the plan of the spouse or domestic partner of the non-custodial parent (if any) pays last.

- **Rule 5:** *Active or Inactive Employee.* A plan that covers the person as a former employee or leased employee (or dependent of a former employee or leased employee) is secondary to a plan that covers the person as an active employee or leased employee (or as a dependent of an active employee or leased employee). If the other plan does not have this rule, and the plans do not agree on the order of benefits, then this rule won't apply.

- **Rule 6:** *Continuation Coverage.* COBRA coverage is secondary to the plan covering the person as an employee or retiree. Note: This rule applies only when both plans provide either non-dependent coverage or dependent coverage to the person. However, if one plan provides dependent coverage and the other non-dependent coverage, Rule 2 applies.

- **Rule 7:** *Longer or Shorter Length of Coverage.* If none of the above rules determines the order of payment, then the plan that has covered the person longer pays before the plan that has covered the person for the shorter period of time.

- **Rule 8:** *Other Rules Don't Apply.* If none of the above rules determines which plan is primary, then the expenses are shared equally between the plans.

- *Exception*: Federal law governs when Medicare pays secondary. See "Coordination of Benefits for Participants Eligible for Medicare," below, for more details.

NOTE: Even if your dependent loses eligibility for coverage due to any of the above, you must inform the Veolia Benefits Center within 31 days or your premium for your pre-tax coverage will not be able to be adjusted for the remainder of the Plan year.

You must notify the Veolia Benefits Center any time you obtain or lose other health care coverage. If you or a covered dependent has primary coverage under another medical or dental plan, you must file a claim for benefits under that coverage before your Veolia claim will be processed.

Coordination of Benefits for Participants Eligible for Medicare

If you or any of your dependents are eligible for Medicare, the coordination of your benefits works differently from the National Association of Insurance Commissioners (NAIC) rules. Congress has established rules to determine whether Medicare or another plan pays first. In accordance with these rules, participation data may be provided to the agency that administers Medicare - Center for Medicare/Medicaid Services (CMS). CMS will use this data to determine which plan pays primary if you or your dependent are covered under a group health plan and Medicare.

How the 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, the Plan is primary and pays benefits as described in this handbook. If the Plan is secondary to Medicare, the Plan pays the difference between what Medicare pays and the benefits available under the Plan. If you file a medical claim with the Plan, be sure to submit the explanation of benefits (EOB) you receive from Medicare. 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 Claims Administrator 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 Plan and Medicare (the Plan is primary and Medicare is secondary); or

- Under Medicare only because you were not already covered under Veolia'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 the Plan if you do not elect coverage.

Please note: If you or your covered dependent has end-stage renal disease, the 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 generally becomes primary. When this provision determines that Medicare is primary, the Plan pays secondarily regardless of whether you or your dependent (whoever is eligible) has enrolled in 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) and you or your spouse is Medicare-eligible, Medicare is primary regardless of your or your covered spouse's age. You are responsible for notifying the Veolia Benefits Center if you or your spouse becomes Medicare-eligible.

SUBROGATION AND REIMBURSEMENT

Sometimes, you or a covered dependent may have a claim for an illness, injury, disability or death, such as from a car accident, that someone else is responsible to pay. The portion of the expense that the other party (which may be an individual, a company or an insurer) is responsible for paying is not considered a covered expense under the Plan. Also, the Plan does not provide benefits if there is other coverage under any automobile policy, homeowner's policy, workers' compensation, or similar insurance coverage. However, the Plan may advance you payment of the expense as a benefit in exchange for you and your dependents granting the Plan the right of subrogation, reimbursement and recovery. By enrolling in the Plan, as well as by applying for payment of covered expenses, you and your covered dependents are subject to and agree with the following rules.

- **Reimbursement agreement** – If you or your covered dependent have expenses that are excluded because they are or may be the responsibility of a third party, you or your covered dependent must sign the Plan's reimbursement agreement in order to receive Plan benefits. The agreement acknowledges your or your covered dependent's obligation to reimburse the Plan from the first dollars recovered from any source. If 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 or your covered dependent do not execute the agreement, the Plan is not obligated to provide any benefit payments.

- **Right of reimbursement** – Whether or not you or your covered dependent execute a reimbursement agreement, in the event that the Plan provides benefits and you or your covered dependent recover a payment, either by settlement, judgment, no-fault automobile insurance statute, or otherwise, from any third party, then you or your covered dependent 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 the recovery. This right of reimbursement applies regardless of the label assigned to the recovery, and regardless of any purported allocation or itemization of such recovery to specific types of injuries. This right provides the Plan with priority over any funds paid by a third party or insurer, without regard to whether you or your covered dependent has been made whole. If the recovery is for damages other than for medical or dental care expenses, such as pain and suffering, you or your covered dependent will still be required to reimburse the Plan first. The Plan has a lien on any such recovery in the amount of the benefits paid by the Plan.

- **Right of subrogation** – Whether or not you or your covered dependent execute a reimbursement agreement, if the Plan pays for an expense for which another party was responsible, the Plan is subrogated to all of your or your covered dependent's rights of recovery against any party to the extent of the benefits provided. This means that 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. If the Plan is precluded from exercising its right of subrogation or chooses not to exercise that right, the Plan has discretion whether or not to pay benefits.

Following are some examples of when the subrogation and reimbursement rights described above apply:

- ✓ Payments made directly by a third party or any insurance company on behalf of the third party or any other payments on behalf of the third party;
- ✓ Any payments or settlements or judgment or arbitration awards paid by any insurance company under any uninsured or underinsured motorist coverage;
- ✓ Any other payments from any source designed or intended to compensate a participant for injuries sustained as the result of negligence or alleged negligence of a third party;
- ✓ Any worker's compensation award or settlement;
- ✓ Any recovery made pursuant to no-fault insurance; and
- ✓ Any medical payments made as the result of such coverage in any automobile or homeowners insurance policy.

- **Duty to cooperate** – You and your covered dependent 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 or your covered dependent must notify the Plan before filing any suit and may not settle any claim against a third party without giving notice to and obtaining the consent of the Plan Administrator. If you or your covered dependent notify the Plan before suit or settlement, the Plan may retain your or your covered dependent's attorney to represent the Plan. If the Plan hires your or your covered dependent's attorney, the Plan will agree with the attorney on the amount of attorneys' fees and expenses that the Plan will pay. The Plan is not bound by the amount or percent of your or your covered dependent's attorneys' fees, nor may they be subtracted from the amount that is required to be repaid to the Plan without the Plan's consent. If you do not timely notify the Plan of suit or settlement, or 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 because of your actions or failure to act, in addition to any other rights or remedies that the Plan may have.

- **Equitable Lien and other Equitable Remedies –** The Plan will have an equitable lien against any rights you or your covered dependent may have to recover the reimbursable expenses from any party, including an insurer or another group health program, but limited to the amount of reimbursable payments made by the Plan. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the Plan has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made.

  This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, you, your covered dependent, your or your covered dependent's attorney, and/or a trust) as a result of an exercise of your or your covered dependent's right of recovery (sometimes referred to as "proceeds"). The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of Company, the Plan may reduce any future covered expenses otherwise available to you or your covered dependent under the Plan by an amount up to the total amount of reimbursable payments made by the Plan that is subject to the equitable lien.

  This and any other provisions of the Plan concerning equitable liens and other equitable

remedies are intended to meet the standards for enforcement under ERISA that were enunciated in the United States Supreme Court's decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 122 S.Ct. 708 (2002), and Sereboff v. Mid Atlantic Medical Services, 126 S. Ct. 1869 (2006) and their progeny.

- **Right of recovery or offset** – The Plan has the right to withhold the payment of benefits under this Plan if you or your covered dependent do not comply with these requirements, and has the right to recover any benefits paid to you, your covered dependent or your or your covered dependent's health care provider in error. The Plan may stop paying benefits under a reimbursement agreement if, the Plan Administrator determines that, you have failed or are failing to fulfill your duty to cooperate. These rights are in addition to any other rights and remedies that the Plan may have. In connection with this right of recovery or offset, please consider the following:

  - ✓ You or your adult covered dependents may not assign any rights to recover medical expenses from any party to any of your or your covered dependent's minor child or children without the prior express written consent of the Plan. The Plan's right to recover (whether by subrogation or reimbursement) applies to settlements or recoveries of decedents, minors and incompetent or disabled persons.

  - ✓ You may not make any settlement that reduces or excludes, or attempts to reduce or exclude the benefits provided by the Plan.

  - ✓ The Plan's rights described above cannot be defeated nor reduced by the application of any "made-whole doctrine" or similar doctrine or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

  - ✓ You or your covered dependents may not incur expenses on behalf of the Plan in pursuit of the Plan's rights. Specifically, neither court costs nor attorney fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right cannot be defeated by any so-called "fund doctrine" or similar doctrine.

  - ✓ The Plan has the right to recover the full amount of benefits provided without regard to any claim of fault on the part of any participant, whether under comparative negligence or otherwise.

  - ✓ The benefits under the Plan are secondary to any coverage under no-fault or similar insurance.

  - ✓ If you do not honor your obligations, the Plan will be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to attorney fees, litigation, court costs and other expenses.

HOW LONG COVERAGE CONTINUES

Generally, your benefit coverage continues while you are still working with Company as an eligible employee and you are contributing your appropriate share of the cost of coverage.

Leaves of Absences

Unpaid Military Leave

If you lose coverage because you enter into active military duty covered under the Uniformed Services Employment and Reemployment Rights Act, you and your covered dependent are eligible to continue your health care coverage under COBRA as long as you pay the cost to continue your Veolia health care coverage, including the Health Care FSA. Under USERRA, the cost for the first 30 days of continuation coverage for you and your covered dependents is the same cost paid by active employees, and your continuation coverage period is 24 months instead of 18 months. See "Health Care Continuation Rights" later in this section for more information about your rights to continue your health care coverage under COBRA.

For more information regarding your rights under the Uniformed Services Employment and Reemployment Rights Act of 1994, please contact your local HR business partner.

Other Leaves of Absences

Your health and welfare coverage will continue during an approved paid leave of absence, whether or not your leave is taken under the Family and Medical Leave Act of 1993 (FMLA) and the cost of coverage will continue to be deducted from your pay on either a pre-tax or after-tax basis (as it was before your leave). If you choose, you may stop your health and welfare coverage during an *unpaid* leave of absence. But, if you continue coverage during your unpaid leave, required contributions for your elected benefit options are either made before you leave with advanced pre-tax dollar or after-tax dollars during your leave. See "Coverage During Leaves of Absences" under "Changing Coverage During the Year" above for more details.

When Coverages Ends

Your Coverages

Your coverage ends upon the first of the following to occur:

- Your employment with the Company ends (e.g., you retire, quit, or are terminated);
- You are no longer eligible to participate (e.g., you do not meet the eligibility requirements outlined in your collective bargaining agreement);
- You fail to timely pay your required contributions;
- You elect to terminate coverage;
- You go out on strike or are locked out;
- You employer ceases to participate in the benefit program;
- The Company terminates the benefit program; or
- 90 days after the Company requests repayment of overpayment or amounts that are subject to reimbursement, unless you agree to repay such amounts..

The Plan Administrator also reserves the right to cancel your coverage for Fraud or deception in the application for and use of Plan benefits. Cancellation is effective immediately on the date the notice of cancellation is mailed, unless the notice specifies a later date.

Termination of any health, dental, vision, prescription drug or group legal coverage will be effective as of the end of the month in which the event occurs. Termination of all other coverage (e.g., Disability, Life, Accident) will be effective on the day the triggering event occurs. *For example, if your employment with Company ends on May 17, your life insurance coverage will end on May 17, while your medical coverage will end on May 31, subject to your right to continue health care coverage, including the Health Care FSA, under COBRA and your right to convert or continue certain insurance coverage.*

Your Dependent's Coverage

Your dependent's coverage ends upon the first of the following to occur:

- When your coverage ends; or
- Your dependent no longer meets the eligibility requirements.

If you intend to leave the Company, be sure to check with the Veolia Benefits Center about your benefit status as soon as possible. In addition, you or your dependent may be able to elect COBRA coverage for continued health care coverage after coverage ends or you may convert certain life insurance coverage to individual policies if you no longer qualify for group coverage through Veolia.

Certificates of Creditable Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Affordable Care Act (ACA) make it easier for people changing jobs to be eligible for medical coverage without being subject to a new employer's pre-existing condition exclusion.

When you leave the Company and lose medical coverage, you or your dependents will be provided automatically with a certificate that shows how long you and/or your dependent have had coverage with Company. This written "certificate of creditable coverage" confirms the length and type of coverage you had under Company's medical program. Using this certificate, you will be able to

reduce or eliminate any pre-existing condition exclusion a new employer's plan or insurance policy imposes.

The following rules apply to certificates of creditable coverage under the Company's medical program:

- Your certificate shows only your "creditable coverage" beginning on your first day of coverage under the medical program, including coverage under the PPO or EPO or HDHP (HSA Gold or Silver).
- You will not receive creditable coverage for any medical coverage you had before a break in coverage of 63 days or more.

If you or your dependents elect COBRA continuation coverage, another certificate of creditable coverage is provided when COBRA continuation coverage ends. If you do not receive a certificate, or if you lose your certificate, you may request another one within 24 months after your coverage ends. Please contact the appropriate Claims Administrator to obtain a certificate. See "Plan Information" under the "General Information" section for the appropriate Claims Administrator.

Please note that Certificates of Creditable Coverage will no longer be issued starting in 2015 as the ACA's provision no longer allow for exclusions from coverage due to a pre-existing condition.

INSURANCE CONVERSION OR CONTINUATION RIGHTS

Conversion Rights

When certain group insurance ends, you or your covered dependents may obtain individual insurance coverage with the same insurance company without satisfying any evidence of insurability requirements. This is called a "conversion right". To determine whether you have conversion rights, please check the applicable certificate of coverage.

Portability Rights

Alternatively, if you have supplemental life insurance coverage and your coverage ends, you may elect to continue group coverage under a portability plan by paying the premiums due directly to the insurance company instead of converting the coverage to an individual policy. To determine whether you have portability rights, please check the applicable certificate of coverage.

HEALTH CARE COVERAGE CONTINUATION RIGHTS (COBRA)

COBRA

A federal law known as COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) allows you and your covered dependent to continue your medical, dental, vision and, in certain circumstance, Health Care FSA coverage (on an after-tax basis) in certain situations when coverage would otherwise end. Upon a qualifying event (described below), you and your covered dependents may be able to continue these coverage. If otherwise eligible, you and each of your covered dependents have an independent right to elect COBRA continuation coverage.

Many states have health care continuation laws too. For any fully-insured Benefit Program that is subject to COBRA, if your state provides for greater benefits under a state continuation law than are provided under COBRA, you may be entitled to elect either COBRA or continuation coverage under your state's law.

While not required by COBRA, the Plan provides COBRA-like coverage for domestic partners, similar to the coverage provided to spouses under COBRA.

When to Elect COBRA

If you and/or your dependents choose continuation coverage through COBRA, you and your covered 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 the coverage that is in effect for you and your covered dependents on the day before your qualifying event. COBRA coverage does not create new classes of covered individuals. To be eligible for continuation of coverage, your Company-provided health care coverage must be in effect on the date before the qualifying event. For your dependents to be eligible for continuation of coverage, they must also be enrolled for coverage on the day before the qualifying event.

Participation

As noted above, if you elect COBRA coverage, you will receive the same coverage that was in effect on the day before the qualifying event. However, you may change your coverage choices during the annual enrollment period that falls during your COBRA continuation coverage period. If your covered dependents elect COBRA, these same rights apply.

COBRA coverage takes effect on the date coverage is lost on account of the qualifying event if a timely election is made. While the Company will notify the COBRA Administrator of your qualifying event in the case of your termination from employment (or service, as applicable), reduction in hours or death, it is your (or your covered dependent's) responsibility to notify the COBRA Administrator 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 HIPAA "special enrollment" rules outlined earlier. Your newborn or adopted child's coverage begins immediately.

To continue coverage, you or your affected covered dependents (each, a "qualified beneficiary") are required to pay the entire cost, plus an administrative fee, as allowed by law.

Enrollment In Health Insurance Marketplaces

If you experience a qualifying event that would trigger a COBRA right, you also have the option of seeking coverage through the Health Insurance Marketplaces. Coverage on the marketplaces would be under a different plan than your current medical plan, but you might qualify for premium tax credits that could reduce the cost of your coverage (potentially making it cheaper than COBRA). To learn more about the Health Insurance Marketplaces, visit www.healthcare.gov.

Administration of COBRA

If you have any questions about COBRA or if you are required to notify the COBRA Administrator of any event to trigger COBRA obligations, please contact the Veolia Benefits Center. Upon any required notification by you, the Veolia Benefits Center will contact the COBRA Administrator to send you any necessary paperwork. The Plan Administrator has engaged PayFlex as its COBRA Administrator to assist it with the sending and receiving of COBRA information, including the collection of COBRA premiums if elected by participants.

Snapshot of COBRA Coverage

Here is a snapshot of who is eligible for COBRA continuation coverage, under what circumstances, and how long COBRA continuation coverage continues for health care coverage. If one of the events listed in the chart occurs, you and your enrolled dependents may apply for COBRA coverage.

Qualifying Event	Who Is Eligible for COBRA	Maximum COBRA Period*
▪ Termination of your employment (or service, as applicable) for any reason except gross misconduct	You and your enrolled dependents	18 months
▪ Reduction in hours of employment (including a military leave of absence)**	You and your enrolled dependents	18 months
▪ You become laid off	You and your enrolled dependents	18 months
▪ You do not return from a FMLA leave of absence	You and your enrolled dependents	18 months
▪ You or your covered dependent become disabled	You and your enrolled dependents	18 months up to 29 months***
▪ Your death	Your enrolled dependents	36 months

Qualifying Event	Who Is Eligible for COBRA	Maximum COBRA Period*
▪ Divorce, termination of domestic partnership or legal separation (unless a QMCSO provides otherwise)	Your enrolled dependents	36 months
▪ Your child no longer meets the definition of dependent under the Plan	Your covered dependent	36 months

*The maximum COBRA period is measured from the date you lose coverage on account of the qualifying event. If eligible for COBRA under the Health Care FSAs, the maximum COBRA period is through the end of the calendar year in which the qualifying event occurs. See "Health Care Flexible Spending Account" below for details.
**Note that in the event you become entitled to COBRA coverage due to a loss of coverage triggered by a military leave of absence covered by the Uniformed Services Employment and Reemployment Rights Act of 1994, you will receive continued coverage at the same cost paid by active employees for the first 30 days of your military leave. Also, your continuation coverage period is 24 months, not 18 months.
***See "COBRA Coverage for Disabilities" below for details.

Important Notes:

- If a second qualifying event occurs within the 18- or 29-month period, the COBRA continuation period for health care coverage may be extended up to 36 months from the date you lost coverage on account of the first qualifying event.

- Please keep the Veolia Benefits Center informed of any change in your or your covered dependents' address so that you and your covered dependents can receive the necessary information concerning your rights to COBRA continuation coverage.

Health Care Flexible Spending Account

You and your covered dependents are also permitted to elect COBRA continuation coverage for the Health Care FSA upon a qualifying event provided you have not received reimbursement for amounts that exceed the balance in your Health Care FSA as of the date the qualifying event occurs (i.e. you have not "overspent" your Health Care FSA). In this case, you would continue contributions on an after-tax basis. The COBRA rules discussed in this section are the same, except that the maximum period for which you may continue after-tax contributions to your Health Care FSA is the remainder of the Plan year in which the qualifying event occurs.

Electing COBRA for the Health Care FSA 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 FSA. If you have not incurred enough expenses at the time of your qualifying event to recover your contributions to the Health Care FSA, then you should consider electing COBRA in order to extend the coverage period long enough to incur claims that would allow for full reimbursement of the pre-tax dollars (plus the new after-tax COBRA dollars) credited to your Health Care FSA as of the qualifying event, but not past the end of the year. For this reason, COBRA is available to you or your covered dependents only if the amount you could be reimbursed exceeds the amount you would have to pay into the account on an after-tax basis.

For example, assume you authorized an annual contribution of $1,200 to your Health Care FSA. Your employment terminates in October and you have $1,000 credited to your Health Care FSA as of your termination. But, you have incurred reimbursable expenses of only $200 as of your qualifying event, and you have laser eye surgery scheduled for November, expenses which would be reimbursable under your Health Care FSA. In this circumstance, you may wish to elect COBRA and pay $100 for November and December on an after-tax basis, just so you could get reimbursed (instead of forfeit) the amount you already made on a pre-tax basis.

In contrast, if you had incurred reimbursable expenses of $1,000 or more as of your termination, you would not be entitled to COBRA.

COBRA Coverage for Disabilities

As shown in the chart above, COBRA coverage can be extended from 18 months up to 29 months

if you (or another qualified beneficiary) are totally disabled when you (or the other qualified beneficiary) become eligible for COBRA coverage or become disabled during the first 60 days of COBRA coverage. Monthly contributions for continuation coverage increase to 150% (from 102%) of the monthly amount for each of the 11 additional months of continuation coverage. (Any covered dependents can also continue their COBRA coverage during this extension period.)

To be eligible for this extension, the individual must:

- Receive a determination of disability from the Social Security Administration (SSA) that the individual was disabled on the date coverage ended, or become disabled during the first 60 days of COBRA coverage, and
- Notify the COBRA Administrator within 60 days after the later of:
  - ✓ the date of the SSA's determination of disability; or
  - ✓ the date of the qualifying event.

If the SSA determines that the individual is no longer totally disabled, continuation of coverage will cease. The individual must notify the COBRA Administrator within 30 days of any such finding. Coverage will terminate on the earlier of the first day of the month that is at least 30 days after the SSA's findings or at the end of the 29 month period.

Reporting a Qualifying Event

You or your affected covered dependent must notify the Veolia Benefits Center either in writing or orally within 60 days after the date on which coverage is lost on account of any of the following qualifying events:

- You divorce or become legally separated;
- Your child no longer meets the definition of a dependent (e.g. due to age limit); or
- You (or your covered dependent) are determined to have been disabled under the Social Security Act when coverage ended or at any time during the first 60 days of receiving COBRA continuation coverage.

When you or your affected covered dependent contact the Veolia Benefits Center, be sure to inform the Veolia Benefits Center of the specific event, the date of the event, and who is affected.

The COBRA Administrator sends you and/or your affected covered dependent a notice and election form, including the cost of coverage, within 14 days of receiving this notification.

The Veolia Benefits Center informs the COBRA Administrator within 30 days of the loss of your coverage on account of any of the following qualifying events:

- Reduction in hours that makes you ineligible for coverage;
- You are laid off;
- You do not return from a FMLA leave of absence;
- Your termination of employment (or service, as applicable) for any reason other than gross misconduct;
- You become entitled to Medicare; or
- Your death.

The COBRA Administrator sends you and/or your affected covered dependents a notice and election form, including the cost of coverage, within 44 days after one of these qualifying events occur.

Deciding Whether or Not to Continue Coverage

You have 60 days from the day coverage would otherwise end (or from the day the notice is sent to you, if later) to choose continuation coverage.

In order to continue your health care coverage, you and/or your covered dependents must pay the full cost of coverage, plus a 2% fee for administrative costs (or a 50% administrative fee in the case of an 11-month extension due to disability).

Your first payment (due within 45 days of your election) must include your COBRA contribution for the entire period from the date coverage ended through the month of the payment. Subsequent contributions are due on the first of the month, whether or not you receive a bill. If the COBRA

Administrator does not receive your monthly contribution within 30 days of the first of the month, coverage is canceled as of the last day of the month in which you paid a contribution. If you do not choose to continue coverage, you should make the appropriate election on the election form and return it to the COBRA Administrator. In that case, your health care coverage ends on the day on which the qualifying event occurred.

When Continuation Coverage Ends

Continuation coverage ends when any of the following events occurs:

- You (or a covered dependent) reach the end of the applicable maximum COBRA period for coverage;
- You (or a covered dependent) do not pay a monthly contribution within 30 days of its due date;
- Upon your or your covered dependent's written request to cancel coverage;
- You (or a covered dependent) become entitled to Medicare;
- You (or a covered dependent) become covered under another group medical or dental plan that does not contain a pre-existing condition rule; or
- Company ceases to provide any group health plan coverage.

Please inform Veolia HR Shared Services of any changes in address or in personal circumstances so that you and your covered dependents can receive the necessary information concerning your rights to continuation of coverage. However, if you are already receiving COBRA, please contact the COBRA Administrator to update any changes in address or in personal circumstances.

Health Care System Assistance Program

The Company partners with HealthAdvocate to offer the following services to help you navigate your health care:

- Locate doctors, hospitals, dentists and other providers
- Get cost estimates for common medical procedures
- Help to resolve insurance claim problems
- Answer questions about test results, treatments and medications
- Assist with eldercare issues, including Medicare and in-home care
- Aid in the transfer of medical records, X-rays and lab results

For more information, call 1-866-695-8622 or go to HealthAdvocate.com/VeoliaNorthAmerica.

CLAIMS PROCEDURES

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.

The respective sections of this handbook inform you whether or not you need to file a claim for benefits and, if you do, the information you need to complete a claim for benefits. This section informs you of the time frames for responding to initial claims as well as the appeals process. When filing a claim, please check with the applicable claims administrator to be sure that its address has not changed.

The time frames for responding to claims depend on the type of claim (eligibility claim or claim for benefits, described below) and the program under which you file a claim (e.g. medical, disability).

Under the Plan, all claims must be submitted within one year after the date the claim accrues (generally, when the services are or should have been provided). Please note that if a shorter time period is provided in the individual program sections, the shorter period will apply. *For example, PPO claims must be submitted within one year following the date the claim accrues*.

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. If, after you have exhausted the claims procedures, you wish to challenge the decision of

the Plan Administrator or Claims Administrator, as applicable, you will have 180 days from the date you receive your final claims denial.

What is a Claim?

You may have two types of claims.

- ***Claim Regarding Eligibility or Enrollment.*** This is a claim involving eligibility for coverage under a benefit program or enrollment in a benefit program. *For example, you want to enroll your dependent for coverage or change previously elected coverage options during the year, but you did not experience a mid-year event. Or, you enrolled for coverage, but the confirmation statement you receive shows you enrolled in an option that you did not elect*. Note that a claim regarding your eligibility may overlap with a claim for benefits (described below). That is, you may be denied a benefit because you are shown as not eligible to participate in the program that denied your benefit.

  The ERISA Fiduciary Committee of the Veolia North America Employee Benefit Plans, which is the Plan Administrator, determines these types of claims. Please see General Information at the end of this handbook for contact information.

  If you are denied disability or life coverage because you did not satisfy an insurance requirement for coverage (e.g. evidence of insurability), any inquiries or claims should be directed to the Claims Administrator (the insurance company for the coverage).

- ***Claim for Benefits.*** A claim for benefits is the more common type of claim and is a request that benefits be paid under the applicable program or, with respect to the Health or Dependent Care FSAs, a request that expenses be reimbursed. For the health programs, when you make a claim, you generally receive an explanation of benefits (EOB) telling you that a claim has been made (even if you did not fill out the claim form), and how much, if any, of the claim is paid for under the health program. If an EOB denies or limits payment for the services or supplies provided to you, you can appeal that decision. For the disability and life programs, you will need to file a claim for benefits – whether it be for benefits due to a disability you incur or for life insurance proceeds.

  You may or may not need to file a claim to receive benefits. As mentioned earlier, the respective sections of this handbook will tell you whether a claim needs to be filed. Generally, under the medical program, if you elect coverage under an available EPO and receive services from an EPO provider, or if you elect coverage under a PPO or high deductible health plan and receive in-network services, you do not need to file a claim form in order for the claim to be submitted to the Plan and to receive an EOB. However, if you elect coverage under the PPO or high deductible health plan and receive non-network services or you live outside of a PPO high deductible health plan area, a claim form must be submitted before an EOB is issued.

  Under the vision care programs, if you receive services from a VSP network doctor, you do not need to file a claim form to receive an EOB. However, if you receive services from a non-VSP provider, you must file a claim before an EOB will be issued.

  If you contribute to and seek reimbursement for an eligible expense under the Health Care FSA or the Dependent Care FSA, a request for reimbursement is a claim for benefits. For the Health Care FSA, your claim would be considered a post-service claim under the medical benefit claims procedures. For the Dependent Care FSA, it is simply a claim. If reimbursement is denied, that is an adverse benefit determination which you can appeal. Separate time frames apply for these claims, as further described below.

  For the disability and life programs, EOBs are not issued. A claim must be filed if you become disabled and seek disability benefits, or, alternatively, life or accident proceeds become available.

Health Benefit Claims Process

These procedures apply to the health care coverage programs (medical, prescription drug, dental, vision and Health Care FSA), which are all referred to as “health benefit” claims.

Participation

As noted above, the Plan Administrator has the authority to decide whether an individual is eligible to participate in the Plan. A Claims Administrator has the authority to decide the level of benefits that are available to an individual. The appropriate Claims Administrator depends on the program, and for medical, also depends on the coverage option you elected (PPO, high deductible health plan or one of the EPOs). See the chart in the "General Information" section for contact information for the applicable Claims Administrators.

An "**urgent care claim**" is any medical benefit claim where applying the non-urgent care time frames (i) could seriously jeopardize your health or ability to regain maximum function, or (ii) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain without the care or the treatment that is the subject of the claim.

A "**pre-service claim**" is a medical benefit claim that requires approval before you can receive coverage (in whole or in part) for the medical care.

A "**post-service claim**" is any other medical benefit claim, for example, a claim for reimbursement after the medical care is received.

Initial Claim Decision

When a claim is received for a health benefit, the Plan Administrator must decide whether the individual is covered under the Plan or the Claims Administrator must decide whether (or at what level) the health benefit is covered under the Plan. When a health benefit is provided or denied, you will receive a notice explaining how the benefit level was calculated or why benefits have been denied (the EOB, generally). 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 (may be extended up to an additional 15 days);
- For a post-service claim, 30 days after the claim is received (may be extended up to an additional 15 days).

For a pre-service or post-service claim, these time periods may be extended for up to 15 days as long as the Claims Administrator determines that such an extension is necessary due to matters beyond the Plan's control and notifies you before the original deadline. This notice will describe why the extension is necessary. If you do not properly submit all the necessary information for your request for benefits, the Claims Administrator must notify you and tell you what information is missing. You have 45 days to provide the information needed to process your request for benefits. While the Claims Administrator is waiting on your additional information, that time period does not count towards the time frame in which the Claims Administrator must decide your claim.

For an urgent care claim, you may 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 authorized 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 authorized representative) 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 Claims Administrator may approve a course of treatment that is provided over time or for a specific number of treatments. If the Claims 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 Claims Administrator at least 24 hours before the approved course of treatment will expire. If you do so, the Claims 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 written notice of the Claims Administrator's decision based on whether that request is an urgent care or pre-service claim

Appealing a Medical Claim Denial

If you disagree with a coverage decision or denial, you (or your authorized representative) may request a full review by the Claims Administrator.

You must submit a request for review 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. If you want to appeal a decision on benefits, send your appeal to the Plan Administrator (for eligibility claims) or the Claims Administrator (for benefit level claims) listed in the "General Information" section of this handbook.

Your appeal will be reviewed. Someone other than the person who made the first decision on your claim must make this review. The Claims 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 Claims 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 the Claims Administrator's findings and decision in writing.

If your final appeal is denied, you may have the right to have your claims heard by an Independent Review Organization (IRO). This is an organization that will review your claims which is independent of the Claims Administrator. This option is only available for claims involving medical judgment or for rescissions (retroactive terminations of coverage). You should file your claim with the IRO no later than four months following the final denial of your claim. If your claim is urgent, you may file your claim with the IRO following an initial claim denial. For more information on this voluntary appeal level, contact the Claims Administrator.

Generally, this notice will be provided within a certain period after receiving the appeal, as follows:

Claim Type	PPO, EPO, HDHP, Prescription Drug, Vision, Dental, Health FSA
Urgent Claim	72 hours
Pre-Service Claim	30 days
Post-Service Claim	60 days

Claims Decisions Notices

The notice given to you concerning the decision on either your initial claim or your appeal (except as noted) will include:

- The name of the health care provider and the date of the service;
- The denial code and its corresponding meaning, and a statement regarding the availability of the diagnosis and treatment, upon request (not applicable for dental, vision and Health Care FSA claims);
- 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;
- For an appeal, a description of the external appeal procedures (not applicable for dental, vision and Health Care FSA claims);
- The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman (not applicable for dental, vision and Health Care FSA claims); and
- A statement of your right to bring a civil action under ERISA following a denial of the claim upon review.

Disability, Life and Accident Benefits Claims Process

These procedures apply to the disability, life and accident programs (collectively, the "insurance programs").

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
- For a medical or disability claim, state the Plan's policy or guideline regarding the benefits for your diagnosis, whether or not it was relied upon.

Participation

The Plan Administrator has the initial authority to decide whether an individual is eligible to participate in the Plan. For the disability program, the Claims Administrator 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, and for the life and accident program, whether proceeds are payable and to whom. See "Applying for Benefits" under the respective sections for information on how to apply for benefits. When Short Term Disability or Long Term Disability 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 Claims Administrator notifies you in writing that an extension (not to exceed 30 days unless the Claims Administrator needs to extend that period for another 30 days) is needed. If you do not properly submit all the necessary information for your request for benefits, the Claims Administrator must notify you and tell you what information is missing. While the Claims Administrator is waiting on your additional information, that time period does not count towards the time frame in which the Claims Administrator must decide your claim.

If you think that a payment calculation or denial is wrong, you may request a full review by the Claims Administrator 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 "Relevant Documents" for a description of these documents. If you want to appeal a decision on disability benefits, send your appeal to the Claims Administrator listed in the "General Information" section of this handbook.

The Claims Administrator will review your appeal. Someone other than the person who made the first decision on your claim must make this review. The insurer 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 Claims Administrator must consult with a health care professional who has the appropriate training and experience in the field of medicine involved. After the Claims Administrator 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 45 days) after it receives your appeal. Again, if you do not properly submit all the necessary information for your request for benefits, the Claims Administrator will notify you and tell you what information is missing. While the Claims Administrator is waiting on your additional information, that time period does not count towards the time frame in which the Claims Administrator must decide your claim.

The notice given to you concerning the Claims Administrator's decision on either your initial claim or your appeal (except as noted) 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 concerning whether your disability is mental or physical), 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;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records or other information relevant to your claim; and
- A statement of your right to bring a civil action under ERISA following a denial of the claim upon review.

Dependent Care FSA/Business Travel Accident Claims Process

These procedures apply to the Dependent Care FSA and the Business Travel Accident.

The Plan Administrator has the authority to decide whether an individual is eligible to participate in the Plan. A Claims Administrator has the authority to decide the amount of benefits that are payable to an individual. See the chart in the "General Information" section for more information on the applicable Claims Administrators.

In no event can you (or any other person) challenge a decision in court until this claims procedure has been complied with and exhausted.

For the Dependent Care FSA, you submit an initial claim for benefits when you request reimbursement for a dependent care expense from PayFlex, the Claims Administrator for the Dependent Care FSA.

If you think that a payment calculation or denial is incorrect, you may request a full review by the appropriate Claims Administrator for the program 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 comments in writing. See "Relevant Documents" for a description of the these documents. If you want to appeal a decision, send your appeal to the insurance company listed in the "General Information" section of this handbook.

The appropriate Claims Administrator will review all disputed claims. It 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. The notice given to you concerning the Claims Administrator's decision on either your initial claim or your appeal (except as noted) 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;
- For an initial claim, a description of the appeal procedures;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records or other information relevant to your claim; and
- A statement of your right to bring a civil action under ERISA following a denial of the claim upon review.

HIPAA PRIVACY RIGHTS

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.

The Company continues its commitment to maintaining the confidentiality of your private medical information. This notice describes the legal obligations of the 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 Plan 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 Plan listed below.***

This notice applies to the Company employees, former employees, and dependents who participate in any of the following benefit programs under the Plan:

- Medical benefits
- Dental benefits
- Vision benefits
- Prescription drug coverage

- Health Care Flexible Spending Account program
- Employee Assistance Program
- Wellness Program

In this notice, the terms "we," "us," and "our" refer to the Plan, all Company employees involved in the administration of the Plan, and all third parties who perform services for the Plan. Actions by or obligations of the Plan include these Company employees and third parties. However, Company employees perform only limited Plan functions – most Plan administrative functions are performed by third party service providers.

Please note, the Company also has a general privacy policy to protect your personal information.

What is Protected?

Federal law requires the Plan to have a special policy for safeguarding a category of medical information received or created in the course of administering the Plan, 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 explanation of benefits ("EOB's") sent in connection with payment of your claims are all examples of PHI.

If the Company 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 the Company 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 program, such as the Long Term Disability Program 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 the Plan.

The remainder of this notice generally describes our rules with respect to your PHI received or created by the Plan.

Uses and Disclosures of Your PHI

To protect the privacy of your PHI, the Plan not only guards 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.

CONTACT INFORMATION

If you have any questions regarding this Notice, please contact:

Veolia North America, LLC
Attn: Privacy Officer, Director - Compensation & Benefits
200 East Randolph Street
Suite 7900
Chicago, IL 60601
(321) 433-0955

- ***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; submitting claims for stop-loss (or excess-loss) 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 the Company.*** For the purpose of administering the Plan, we may disclose PHI to certain employees of the Company. 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 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 Plan, provided that We have obtained satisfactory written assurances that the business associates will comply with all applicable Privacy Rules with respect to such Plan.

- ***Research Purposes.*** We may use or disclose a "limited data set" of your PHI for certain research purposes.

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 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 Plans use or disclose your PHI. If an applicable state law imposes stricter restrictions on the 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 Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your 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 Plan's 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 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 Plan's 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 Plan benefits, to administer the Plan, and to comply with the law, it may not be possible to agree to your request. *The law does not require the Plan 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.

Restriction request forms are available from the Privacy Officer. You may make a request for restriction on the use and disclosure of your PHI to the Privacy Officer. Contact information for the Privacy Officer is listed at the beginning of this Notice. When making such a request, you must specify: (1) the PHI you want to limit; (2) how you want the 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 Plan 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 Plan contact you only at work and not at home.

You may request confidential communication of your PHI by completing and appropriate form available from the Privacy Officer. You should send your written request for confidential communication to the Privacy Officer at the address listed on the front of this notice. 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 Plan maintains 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 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 Plan 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 Plan 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 Privacy Officer. Your written request should be sent to the Privacy Officer at the address listed on the front of this Notice. 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 Plans have about you is incorrect or incomplete. You have this right as long as your PHI is maintained by the Plan. 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 Privacy Officer. Your written request to amend your PHI should be sent to the Privacy Officer at the address listed on the front of this Notice. 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 Plan. The accounting will not include (1) disclosures necessary for treatment, to determine proper payment of benefits or to operate the Plan, (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 Privacy Officer. You may request an accounting of disclosures of your PHI from the Privacy Officer. Contact information for the Privacy Officer is listed on the front of this Notice. When making such a request, you must specify the time period for the accounting, which may not be longer than six (6) years prior, 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 Plan's 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. **The Company prohibits retaliation against any person for filing such a complaint.** Complaints should be sent to the Privacy Officer on the front of this Notice.

For more information above HIPAA privacy:

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Additional Information About This Notice

Changes to this Notice: We reserve the right to change the Plan's privacy practices as described in this notice. Any change may affect the use and disclosure of your PHI already maintained by the Plan, as well as any of your PHI that the Plan may receive or create in the future. If there is a material change to the terms of this notice, you will automatically receive a revised notice.

How to obtain a copy of this Notice: You can obtain a copy of the current notice on the Company Intranet or by writing to the Privacy Officer at the address listed at the beginning of this notice.

No guarantee of employment: This notice does not create any right to employment for any individual, nor does it change the Company's right to discipline or discharge any of its employees in accordance with its applicable policies and procedures.

No change to Plan benefits: This notice explains your privacy rights as a current or former participant in the Plan. The Plan is bound by the terms of this notice as it relates to the privacy of your PHI. However, this notice does not change any other rights or obligations you may have under the Plan. You should refer to the Plan document for additional information regarding your Plan benefits.

CONTENTS: MEDICAL

Medical Coverage

Your medical coverage is a key component of the Plan and is administered by Blue Cross Blue Shield of Illinois, called BCBS-IL, or, depending on location, UnitedHealthcare, called UHC.

How Your Medical Coverage Works

This coverage is a group health plan and pays benefits for the treatment of an illness or injury and offers many features, such as preventive health care coverage, well-baby care and prescription drug coverage. 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:

- EPO (Exclusive Provider Organization)
- PPO (Preferred Provider Organization)
  - PPO Gold
  - PPO Silver
- HDHP (High Deductible Health Plan)
  - HSA Gold
  - HSA Silver
- Waiver (no coverage)

Choosing Whom To Cover

You may choose medical coverage for yourself and any one or more of your eligible dependents under the following coverage levels:

- Employee only
- Employee + Spouse
- Employee + Child(ren)
- Employee + Family

See "Participation" for more details on who is considered an eligible dependent and when you can enroll yourself and/or your eligible dependents for medical coverage.

As you read about your coverage, keep the following in mind:

- When you enroll, you may choose any medical plan option that is available to you.
- You have a choice as to how you wish to access and manage your health care – through a Preferred Provider Organization (PPO) or, in certain locations, through an Exclusive Provider Organization (EPO). When you enroll, you may choose any medical plan option that is available in your home ZIP code area.
- The PPO and EPO medical coverage options cover similar medical expenses. Generally, the options differ in the amount you pay in out-of-pocket expenses (deductibles, copayments and coinsurance) and in the way you may access medical care (through a primary care physician, network providers or non-network providers).
- If you elect the PPO or HDHP option, you and your covered dependents can choose to receive medical treatment from any health care provider or from a health care provider who has "contracted" with the PPO/HDHP. The Plan pays significantly higher benefits when you receive care from a contracted PPO/HDHP provider. These contracted providers are known as In-Network providers.
- If you are eligible for and elect medical coverage under the EPO, care generally must be provided by the EPO network providers to be covered. Most EPO services are paid at 100%; however, you may have to make a small copayment for office visits and certain other health care services. Services rendered by non-network providers will generally <u>not</u> be covered.
- If you elect HDHP coverage, each calendar year you and your covered dependents must satisfy the entire deductible before you receive benefits under the plan (except for preventive care). But, you may qualify for Company Health Savings Account (HSA) contributions to assist you in paying for those medical expenses incurred before you hit your deductible.

Medical Coverage

Important note if your dependent resides outside of your service area (determined by your zip code). If you elect to cover your eligible dependent and your dependent resides outside of your service area (e.g. your dependent is away at school or is covered pursuant to a QMCSO) and if you are enrolled in the EPO, then his or her coverage may be limited to emergency only services if the dependent incurs services outside the network area where the dependent resides. If you enrolled in a PPO and your dependent resides in the PPO network, then your dependent can receive benefits at the network level under the PPO if he obtains services from a network provider.

Choosing a Provider

The choice of a health care professional is yours. Neither the Plan nor the Claims Administrator will make that determination for you. Nor will the Plan or the Claims Administrator interfere with your relationship with your health care provider. The Plan simply provides a means to pay for the eligible medical services you receive from your selected provider. If you select Participating Providers or Network Providers, the Plan benefit may be greater than if your provider is not in the network.

A SNAPSHOT OF YOUR MEDICAL COVERAGE

Here is a snapshot of the EPO, HDHP and PPO options as of January 1, 2014.

	EPO	HDHP (HSA)		PPO	
	Participating Providers*	Network Provider	Out-of-Network Provider**	Network Provider	Out-of-Network Provider**
Annual Deductible					
▪ Individual	None	$1,500 (Gold)/ $2,000 (Silver)	$3,000 (Gold)/ $4,000 (Silver)	$500 (Gold)/ $1,000 (Silver)	$1,000 (Gold)/ $2,000 (Silver)
▪ Family	None	$3,000 (Gold)/ $6,000 (Silver)	$6,000 (Gold)/ $8,000 (Silver)	$1,000 (Gold)/ $2,000 (Silver)	$2,000 (Gold)/ $4,000 (Silver)
Benefit Level	Generally, 100% after required copay	Generally, the Plan generally pays 80% (Gold) or 70% (Silver) of the negotiated network fee	Generally, the Plan generally pays 50% of a rate based on the Medicare reimbursement rate	Generally, the Plan generally pays 80% of the negotiated network fee	The Plan generally pays 50% of a rate based on the Medicare reimbursement rate

Medical Coverage

	EPO	HDHP (HSA)		PPO	
	Participating Providers*	Network Provider	Out-of-Network Provider**	Network Provider	Out-of-Network Provider**
Coinsurance	Generally, none	The remaining percentage (generally, 20% (Gold) or 30% (Silver) after deductible) of negotiated network fees you pay as coinsurance.	The remaining percentage (generally 50% after deductible) of a rate based on the Medicare reimbursement rate you pay as coinsurance. **	The remaining 20% (after deductible) of negotiated network fees you pay as coinsurance.	The remaining percentage (generally 50% after deductible) of a rate based on the Medicare reimbursement rate you pay as coinsurance. **
Annual out-of-pocket maximum (includes deductible)					
▪ Individual	$6,350	$3,000 (Gold)/ $5,950 (Silver)	$6,000 (Gold)/ $11,900 (Silver)	$3,000 (Gold & Silver)	$6,000 (Gold & Silver)
▪ Family	$12,700	$6,000 (Gold)/ $11,900 (Silver)	$12,000 (Gold)/ $23,800 (Silver)	$6,000 (Gold & Silver)	$12,000 (Gold & Silver)
Lifetime maximum***	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

*For the EPO option, if services are received through a non-participating provider, they will not be covered.

**Out-of-Network providers do not participate in the PPO. While some Out-of-Network providers still have a contract with the Claims Administrator, any services you receive from an Out-of-Network provider that does not have a contract with the Claims Administrator could be subject to balance billing, meaning you will pay the difference between a percentage of the Medicare reimbursement rate (which is what the plan pays) and the actual amount of the provider's bill. You will also be responsible for any coinsurance and copays. Any amount that is balance billed does not apply toward the out-of-pocket limit.

***Lifetime maximums may still apply for specific benefits.

EXCLUSIVE PROVIDER ORGANIZATION (EPO)

If you elect the Exclusive Provider Organization (EPO) option, you must receive medical care from providers associated with that EPO to receive benefits. With EPOs, there generally are no deductibles to meet or claim forms to file. And, most services are covered at 100%. Therefore, unlike the PPO and HDHP options, you do not have any coinsurance amounts or amounts to pay above contracted reimbursement rates. However, a copayment may be required for such things as office visits and emergency room treatment.

THE HIGH DEDUCTIBLE HEALTH PLAN

If you select coverage under the HDHP option, you have the flexibility to use any health care provider you choose. However, you will receive the biggest benefits from this option if you use In-Network providers.

The High Deductible Health Plan (HDHP) is very similar to the PPO option, described below. However, if you elect the HDHP, you will pay a higher annual deductible than in the PPO or EPO

options. Similar to the PPO, you will have the choice of using in-network or out-of-network providers. You will pay 100% of your eligible health care expenses, including prescriptions, until you reach your annual deductible -- $1,500 for individual coverage or $3,000 for family coverage (in-network). Certain routine preventive care services are covered at 100% though -- no deductible applies. Once you reach the out-of-pocket maximum ($5,000 individual/$10,000 family in-network), the HDHP pays the full cost of covered expenses.

If you choose the HDHP, you can also participate in the Health Savings Account (HSA). An HSA enables you to save for covered medical expenses on a tax-preferred basis. See the HSA section for more information.

There are two HDHP options available to you: HSA Gold and HSA Silver. The HSA Gold option requires you to pay less for out-of-pocket expenses than the HSA Silver option and the Company makes a contribution to your HSA to help you cover any out-of-pocket expenses you incur. The HSA Silver option requires you to pay more for out-of-pocket expenses than the HSA Gold option, but the premium is less. There is also no Company contribution to your HSA for the HSA Silver option, but you may elect to contribute your pre-tax dollars to an HSA to help you cover out-of-pocket medical expenses.

THE PREFERRED PROVIDER ORGANIZATION

If you select coverage under the PPO option, you have the flexibility to use any health care provider you choose. However, you will receive the biggest benefits from this option if you use In-Network providers.

You choose whether to receive your health care from an In-Network provider, an Out-of-Network provider or any combination of the two. You can choose a provider each time you need medical care. The main differences between using an In-Network and Out-of-Network provider are the level of benefits payable and the amount of administrative responsibility you have. However, regardless of whether you select an In-Network provider or an Out-of-Network provider, the PPO has established an annual deductible you must first meet and certain out-of-pocket maximums and other limitations.

There are two PPO options available to you: PPO Gold and PPO Silver. The PPO Gold option requires you to pay less for out-of-pocket expenses than the PPO Silver option. The PPO Silver option requires you to pay more for out-of-pocket expenses than the PPO Gold option, but the premium is less.

LOCATING AN IN-NETWORK PROVIDER

To find an In-Network provider, please visit the Claims Administrator's website at the back of this booklet. You may also contact your Claims Administrator at the telephone number shown on your identification card.

PARTICIPANT COSTS

Level of Benefits

You generally pay less out-of-pocket when you use In-Network providers. In-Network providers are doctors, hospitals, and other health care professionals and facilities that contracted with the Claims Administrator to provide appropriate care while lowering medical costs. When you use an In-Network provider, the HDHP (Gold) and PPO (Gold and Silver) options will generally pay 80%, and the HDHP (Silver) will generally pay 70% of the negotiated network fee and you pay the remaining 20% or 30%, as applicable, after you satisfy the annual deductible. Generally, if you select the EPO option In-Network doctors' fees are covered at 100%.

In contrast, Out-of-Network providers have not negotiated any fees with the Claims Administrator. So, if you use an Out-of-Network doctor, the PPO and HDHP options will generally pay 50% of a percentage of the Medicare reimbursement rate and you pay the remaining percentage, after you satisfy an annual deductible. Medicare reimbursement rate means that Out-of-Network providers' charges are compared to the charges covered by Medicare.

While some Out-of-Network providers still have a contract with the Claims Administrator, any services you receive from an Out-of-Network provider that does not have a contract with the Claims Administrator could be subject to balance billing, meaning you will pay the difference between the applicable percentage of the Medicare reimbursement rate (which is what the plan pays) and the actual amount of the provider's bill. You

will also be responsible for any coinsurance and copays. Any amount that is balance billed does not apply toward the out-of-pocket limit. If you select the EPO option, you are generally not permitted to use Out-of-Network providers.

See the "Benefits Summary" chart later in this section for the benefits payable for specific types of care provided by In-Network and Out-of-Network providers.

The Annual Deductible

The deductible represents the amount you pay each year before the PPO or HDHP pays benefits for covered services. In-Network expenses incurred will apply toward satisfying both the In-Network and Out-of-Network deductibles. However, Out-of-Network expenses incurred will not apply toward satisfying the In-Network deductible.

For example, assume you have already met the $500 deductible for In-Network care under the PPO Gold option, but seek services from an Out-of-Network provider. You will still have to pay an additional $500 of expenses to meet the Out-of-Network deductible of $1,000 before the PPO will pay benefits for covered services.

The annual deductibles are as follows:

EPO Annual Deductible
None

HDHP (HSA) Annual Deductible	
Network Provider	**Out-of-Network Provider**
$1,500 (Gold)/ $2,000 (Silver) individual coverage	$3,000 (Gold)/ $4,000 (Silver) individual coverage
$3,000 (Gold)/ $6,000 (Silver) family coverage	$6,000 (Gold)/ $8,000 (Silver) family coverage

PPO Annual Deductible	
Network Provider	**Out-of-Network Provider**
$500 (Gold)/ $1,000 (Silver) individual coverage	$1,000 (Gold)/ $2,000 (Silver) individual coverage
$1,000 (Gold)/ $2,000 (Silver) family coverage	$2,000 (Gold)/ $4,000 (Silver) family coverage

Under the HDHP option, the individual level deductible is not applicable if you elect family coverage. For family coverage, you and your family must satisfy the entire family deductible before any covered person may receive benefits. Once family members incur combined claims that meet the family deductible amount, no further deductibles will be required before receiving benefits - even if an individual covered person in the family has not yet incurred any expenses.

Assume you elect HSA Gold family coverage, and you've already personally incurred $1,500 of in-network expenses toward your deductible. You or other members of your family must still incur an additional $1,500 of In-Network (or Out-of-Network, or a combination of both) expenses before the HSA Gold option begins to pay a percentage of your covered expenses.

Under the PPO options, if you elect family coverage, a covered person in your family can meet the deductible in one of two ways: (1) that individual can meet the per person deductible, or (2) one or more members of the family can meet the family deductible in the aggregate. Where an individual meets the per person deductible, however, the other members of the family must still meet their own per person deductible (or the family deductible must be met) before the Plan will pay for any benefits.

Just a note, if you enroll for participation in the Health Care FSA, you can use your pre-tax contributions from the Health Care FSA to reimburse yourself for the deductible. If you enroll in the HDHP, you can use your pre-tax contributions to the HSA to reimburse yourself for the deductible.

Medical Coverage

Once you pay the deductible, the HDHP or PPO options pay a percentage of covered expenses (determined at the negotiated In-Network fee for network providers or a percentage of the Medicare reimbursement rate for Out-of-Network providers) for all covered individuals for the rest of the calendar year.

Copayments

A copayment is a flat dollar amount that you pay your provider (for certain services) before benefits are paid. Your copay does not apply toward any out-of-pocket limits. See the "Benefit Summary" charts to see how much, if any, of a copay is required for certain services. For certain services, the full cost of covered expenses may be paid after you meet the copay requirement.

Coinsurance

Coinsurance is the percentage of charges you are responsible for after you meet any applicable deductible or copay requirement. See the "Snapshot" and "Benefit Summary" charts for the percentage the PPO or HDHP options pay. The remaining percentage represents your coinsurance. There is generally no participant coinsurance requirement for the EPO option.

Please note that if you receive Out-of-Network services, the percentage the PPO or HDHP options pay applies only to eligible services that do not exceed a percentage of the Medicare reimbursement rate. If the Out-of-Network provider does not have a contract with the Claims Administrator, you are responsible for any service the PPO or HDHP options do not cover, including any amounts that exceed a percentage of the Medicare reimbursement rate.

Annual Out-of-Pocket Maximum

To protect you and your family from the financial hardship of a serious injury or illness, there is an annual out-of-pocket maximum, as follows:

Benefit Option	Network or Out-of-Network	Annual Out-Of-Pocket Maximum	
EPO	Network Provider	Individual $6,350	Family $12,700
HDHP	Network Provider	Individual $3,000 (Gold) $5,950 (Silver)	Family $6,000 (Gold) $11,900 (Silver)
	Out-of-Network provider	Individual $6,000 (Gold) $11,900 (Silver)	Family $12,000 (Gold) $23,800 (Silver)
PPO	Network provider	Individual $3,000 (Gold) $3,000 (Silver)	Family $6,000 (Gold) $6,000 (Silver)
	Out-of-Network provider	Individual $6,000 (Gold) $6,000 (Silver)	Family $12,000 (Gold) $12,000 (Silver)

The annual out-of-pocket maximum is the most you may be required to pay in covered expenses in one year, and your deductible applies toward meeting the out-of-pocket maximum. Once the out-of-pocket maximum is reached for a year, the Plan pays 100% of covered expenses (i.e., the negotiated In-Network fee or a percentage of the Medicare reimbursement rate, as the case may be) for the remainder of the calendar year. Any amount you pay towards the out-of-pocket maximum each calendar year cannot be applied to the next year's out-of-pocket maximum.

Medical Coverage

Please note that In-Network ***and Out-of-Network expenses*** you incur, including amounts paid toward your deductible, apply to reaching the ***respective*** In-Network and Out-of-Network out-of-pocket maximums. Additionally, the ***Out-of-Network expenses*** you incur ***apply to reaching both the In-Network and Out-of-Network out-of-pocket maximums***. However, the Out-of-Network ***expenses*** you incur ***do not apply*** toward meeting the In-Network out-of-pocket maximum. The out-of-pocket maximum rules are described in the following chart and example:

	Counts Toward In-Network Out-of-Pocket Max?	Counts Toward Out-of-Network Out-of-Pocket Max?
Network Expenses	Yes	Yes
Out-of-Network Expenses	No	Yes

For example, suppose you enrolled for "Employee Only" coverage under the PPO Gold option, which has a $3,000 annual out-of-pocket maximum for In-Network care, including the deductible. If, after meeting the annual deductible, you are responsible for paying coinsurance of $500 for In-Network care and $5,500 for Out-of-Network care during the year, you will have reached the $6,000 for the Out-of-Network out-of-pocket maximum, but not the $3,000 annual out-of-pocket maximum for In-Network care. You will need to pay for an additional $2,500 of covered In-Network expenses to reach the $3,000 annual out-of-pocket maximum for individual coverage and the PPO Gold option will pay 100% of all covered In-Network expenses for the rest of the calendar year.

Certain charges do not apply toward the out-of-pocket maximum, including:

- Any expense that is above the eligible Medicare reimbursement rate or that exceeds the specific benefit limits within the HDHP or PPO options; and
- Additional amounts incurred as a penalty when you do not follow the preauthorization or preadmission procedures required for certain services (described further below).

For example, for the PPO Gold option, assume you receive a service through an Out-of-Network provider, which is covered at 50% of a percentage of the Medicare reimbursement rate. The Out-of-Network provider charges $5,000 for the service. The Plan determines that $4,000 is the applicable percentage of the Medicare reimbursement rate for the service. Your coinsurance amount of $2,000 (50% of the $4,000 Medicare reimbursement rate) will apply toward meeting your out-of-pocket maximum. However, the $1,000 you are required to pay over the Medicare reimbursement rate will not apply toward meeting your out-of-pocket maximum.

Medical Plan Cost Estimator

The Plan has a tool called the "Medical Plan Cost Estimator" to help you compare the coverage options and pick the option that makes the most sense for you and your family. To take advantage of the Medical Plan Cost Estimator, visit www.yourveoliabenefits.com.

Administrative Responsibility

If you receive care from an In-Network provider, your provider will usually handle filing your claims. Remember, though, it is your responsibility to make sure the Claim Administrator receives all necessary information. When you receive care from an Out-of-Network provider, however, you will need to file a claim for benefits. See "Applying for Benefits" at the end of this section. You will have one year from the date you received the service to file a claim.

In either case, you are responsible for administrative details such as notifying the Claims Administrator before receiving certain medical services or obtaining prior authorization for hospitalization, mental health and substance abuse care. As more fully described below, notification of services may be required for a particular service to be covered under the EPO, HDHP or PPO options.

PREADMISSION

The Claims Administrator must be notified if you or a covered family member are planning to receive any of the following services:

- Inpatient hospital services (including emergency care resulting in confinement)

- Inpatient treatment of mental health care, serious mental illness and chemical dependency treatment
- Private duty nursing
- Services received in a coordinated home care program
- Skilled nursing facility services

Please note that approval by the Claims Administrator of the notification does not guarantee that services or benefits will be paid, but failure to provide proper notification can result in a significant reduction in your benefits. You or your covered dependent is responsible for notifying the Claims Administrator.

When Notification is Required

In some instances, you must give notice to the Claims Administrator as soon as you are aware that a service is needed and before service begins. However, for some of the services requiring notification, certain conditions apply:

- For inpatient confinement, the Claims Administrator must be notified of the scheduled admission date at least one working day before the start of the confinement. If the inpatient confinement results from an emergency admission, the notification must occur within two business days following admission.
- For skilled nursing facility services, the Claims Administrator must be notified of the physician recommendation for these services at least one business day prior to the scheduling of the admission.
- For outpatient services which require notification (coordinated home care and private duty nursing), the covered person must notify the Claims Administrator at least one working day before the service is rendered.

How To Notify the Claims Administrator

The Claims Administrator can be notified by calling the number on your card or at the end of this SPD.

The Benefit Reduction

If you or your dependent fail to notify the Claims Administrator within the specified time period a $300 additional deductible will be applied to the care.

Emergency Care

In a true medical emergency, use your best judgment — call 911 or go immediately to the nearest emergency room.

For emergency health care services, you are required to pay the following amounts

Please remember, you (or someone acting on your behalf) are required to call the Claims Administrator at the number on your identification card within 48 hours after your emergency admission to avoid non-notification penalties (described above).

All treatment received during the first 48 hours following the onset of a medical emergency will be eligible for In-Network benefits. After 48 hours, In-Network benefits will only be available if you use network providers and you can be safely transferred to the care of an In-Network provider.

Benefit Option	Participant Obligation
EPO	$100 copay
HDHP (HSA Gold)	Deductible plus 20%
HDHP (HSA Silver)	Deductible plus 30%
PPO (Gold and Silver)	$150 copay (true emergency)/ Deductible plus 20% (non-emergency)

What Is Considered Emergency Care?

An emergency medical condition means a condition displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in serious jeopardy to your health, serious impairment to your bodily functions, or serious dysfunction of any bodily organ or part. Emergency services are medical,

surgical, hospital and related health care services, including ambulance service, performed in conjunction with a medical emergency.

Medical conditions requiring emergency services include, but are not limited to, difficulty breathing, severe chest pains, convulsions, or persistent, severe abdominal pains.

Urgent Care

An urgent care includes situations where waiting to receive medical treatment could seriously jeopardize your life, health or your ability to regain maximum function. Urgent care also includes situations where a failure to receive immediate medical attention could subject you to severe pain that could not be adequately managed without medical care. Urgent care does not rise to the level of emergency care.

What To Do When You Require Emergency or Urgent Care

Wherever you are, if you believe that you require emergency care or urgent care, you should:

- If possible, call — or have someone acting on your behalf call — your physician's office.

  If you are calling during non-business hours and a physician is not immediately available, ask to have the physician-on-call paged. A physician should call you back shortly. Explain your situation and follow the instructions provided.

- Call 911 or go directly to the nearest medical facility for treatment if:

  - ✓ You are unable to contact your physician's office; or

  - ✓ You reasonably believe that the severity of the injury or illness is such that the time required to make the call would result in a serious deterioration in your health or place your life in serious jeopardy.

If your emergency requires that you be hospitalized, you still must notify the Claims Administrator by the end of the second scheduled workday from the date of your emergency admission.

Medical Coverage

BENEFITS SUMMARY

The benefit levels and limits listed below are based on the highest benefit level possible, assuming the Claims Administrator is notified if and when required. Failure to follow the notification requirements reduces the benefit level. Some services that are not covered are highlighted as well.+

TYPE OF SERVICE	**EPO**	**HDHP**		**PPO**	
	Participating Providers	**In-Network Provider**	**Out-of-Network Provider***	**In-Network Provider**	**Out-of-Network Provider***
GENERAL PROVISIONS					
Annual Deductible	None	$1,500 (Gold)/ $2,000 (Silver) Individual Coverage $3,000 (Gold)/ $6,000 (Silver) Family Coverage	$3,000 (Gold)/ $4,000 Silver Individual Coverage $6,000 (Gold)/ $8,000 (Silver) Family Coverage	$500 (Gold)/ $1,000 (Silver) Individual Coverage $1,000 (Gold)/ $2,000 (Silver) Family Coverage	$1,000 (Gold)/ $2,000 (Silver) Individual Coverage $2,000 (Gold)/ $4,000 (Silver) Family Coverage
Annual Out of Pocket Maximum (amount includes deductible)	$6,350 Individual $12,700 Family	$3,000 (Gold)/ $5,950 (Silver) Individual $6,000 (Gold)/ $11,900 (Silver) Family *Network deductible and out-of-pocket **will apply** toward both In-Network and Out-of-Network deductible and out-of-pocket*	$6,000 (Gold)/ $11,900 (Silver) Individual $12,000 (Gold)/ $23,800 (Silver) Family *Out-of-Network deductible and out-of-pocket **will not apply** toward In-Network deductible and out-of-pocket*	$3,000 (Gold)/ $3,000 (Silver) Individual $6,000 (Gold)/ $6,000 (Silver) Family *Network deductible and out-of-pocket **will apply** toward both In-Network and Out-of-Network deductible and out-of-pocket*	$6,000 (Gold)/ $6,000 (Silver) Individual $12,000 (Gold)/ $12,000 (Silver) Family *Out-of-Network deductible and out-of-pocket **will not apply** toward In-Network deductible and out-of-pocket*
Lifetime Maximum per Participant	UNLIMITED	UNLIMITED	UNLIMITED	UNLIMITED	UNLIMITED

Medical Coverage

TYPE OF SERVICE	EPO	HDHP		PPO	
	Participating Providers	**In-Network Provider**	**Out-of-Network Provider***	**In-Network Provider**	**Out-of-Network Provider***
INPATIENT HOSPITAL SERVICES Per Admission Deductible	100% after per admission copay $250 copay	80% after deductible (Gold) 70% after deductible (Silver) None	50% of allowable amount after deductible None	80% after deductible (Gold and Silver) None	50% of allowable amount after deductible (Gold and Silver) None
PENALTY FOR FAILURE TO PREAUTHORIZE (inpatient hospital, skilled nursing facility, coordinated home care program, private duty nursing)	$300	$300	$300	$300	$300
EMERGENCY SERVICES (must call within 2 business days after admission)**	$100 Copay	80% after deductible (Gold) 70% after deductible (Silver)	80% after deductible (Gold) 70% after deductible (Silver)	$150 Copay per emergency; 80% after deductible	$150 Copay per emergency; 80% after deductible
URGENT CARE	$20 Copay	80% after deductible (Gold) 70% after deductible (Silver)	50% after deductible	$50 Copay	50% after deductible
AMBULANCE SERVICES	100%	80% after deductible (Gold) 70% after deductible (Silver)	50% after deductible	80% after deductible	50% after deductible
MEDICAL/ SURGICAL SERVICES					

Medical Coverage

TYPE OF SERVICE	EPO	HDHP		PPO	
	Participating Providers	**In-Network Provider**	**Out-of-Network Provider***	**In-Network Provider**	**Out-of-Network Provider***
Services Performed in Physician Office (non-surgical)	100% after $20 ($40 specialist) copay per visit	80% after deductible (Gold) 70% after deductible (Silver)	50% after of allowable amount deductible	80% after deductible	50% of allowable amount after deductible
Lab & X-Ray	100% (diagnostic lab or x-ray); $40 copay for major imaging services	80% after deductible (Gold) 70% after deductible (Silver)	50% of allowable amount after deductible	80% after deductible	50% of allowable amount after deductible
Outpatient surgical	100%	80% after deductible (Gold) 70% after deductible (Silver)	50% of allowable amount after deductible	80% after deductible	50% of allowable amount after deductible
Outpatient non-surgical	100%	80% after deductible (Gold) 70% after deductible (Silver)	50% of allowable amount after deductible	80% after deductible	50% of allowable amount after deductible
Therapies*					
-Outpatient Short-Term Rehabilitation -Physical Therapy -Chiropractic	100% after $20 ($40 specialist) copay	80% after deductible (Gold) 70% after deductible (Silver)	50% of allowable amount after deductible	80% after deductible	50% of allowable amount after deductible
*Each therapy has a 60 visit annual maximum					

Medical Coverage

TYPE OF SERVICE	EPO	HDHP		PPO	
	Participating Providers	**In-Network Provider**	**Out-of-Network Provider***	**In-Network Provider**	**Out-of-Network Provider***
Maternity Care					
Office Visit	$20 copay first visit; no charge thereafter	80% after deductible (Gold); 70% after deductible (Silver)	50% of allowable amount after deductible	80% after deductible	50% of allowable amount after deductible
Delivery Charges	100%				
Hospital Charges	$250 admission copay				
Infertility coverage					
Testing and diagnosis only; advanced reproductive technology not covered	100%	80% after deductible (Gold) 70% after deductible (Silver)	50% of allowable amount after deductible	80% after deductible	50% of allowable amount after deductible
Voluntary sterilization	100%				
PREVENTIVE CARE	100%	100%	50% of allowable amount after deductible	100%	50% of allowable amount after deductible

Medical Coverage

TYPE OF SERVICE	EPO	HDHP		PPO	
	Participating Providers	**In-Network Provider**	**Out-of-Network Provider***	**In-Network Provider**	**Out-of-Network Provider***
EXTENDED CARE SERVICES Home Health Care (120 visit max) Skilled Nursing Facility (100 day max) Hospice Care	100%	80% after deductible (Gold) 70% after deductible (Silver)	50% of allowable amount after deductible	80% after deductible	50% of allowable amount after deductible
MENTAL HEALTH/ SUBSTANCE ABUSE Inpatient Services Outpatient Services	100% after $250 copay per visit 100% after $20 copay per visit	80% after deductible (Gold) 70% after deductible (Silver)	50% after deductible	80% after deductible	50% after deductible

*Any services received from an Out-of-Network provider that does not have a contract with the Claims Administrator could be subject to balance billing.

**Emergency medical care covered services for the examination and testing of a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection, will be paid at 100% of the eligible charge, regardless of whether you have met your deductible

WHAT'S COVERED

What the Medical Programs Options Cover

The medical program options generally cover some or all of the expenses for the services listed above in the Benefit Summary charts and those listed below. Claims Administrator notification may be required to receive the full benefit level of a service. Some services require prior authorization. Authorizations are generally obtained by your network provider, but if you are not certain, contact the member or customer services department number on your identification card.

Also, check the applicable Benefit Summary chart for specific benefit levels. If the Benefit Summary chart does not list a covered service that is listed below, the service will generally be payable at the levels indicated on the chart, depending on the medical option (e.g., EPO versus PPO) and where you received services. If you have questions, please contact the member or customer services department on your identification card for more information.

HOSPITAL BENEFITS

The benefits described in this section will be provided only when medically necessary and regularly included in the provider's charges.

Inpatient Covered Services

Bed, board and general nursing care when you are in:

— a semi-private room

— a private room

— an intensive care unit

Ancillary services (such as operating rooms, drugs, surgical dressings and lab work)

Preadmission Testing

Benefits are provided for preoperative tests given to you as an outpatient to prepare you for surgery which you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an inpatient in a hospital. Benefits will not be provided if you cancel or postpone the surgery.

These tests are considered part of your inpatient hospital surgical stay.

Partial Hospitalization Treatment

Benefits are available for this program only if it is an administrator program. No benefits will be provided for services rendered in a partial hospitalization treatment program which has not been approved by the Claim Administrator.

Coordinated Home Care

Benefits will be provided for services under a coordinated home care program.

You are entitled to benefits for 120 visits in a coordinated home care program per benefit period.

OUTPATIENT HOSPITAL CARE

The following are covered services when you receive them from a hospital as an outpatient.

Outpatient Hospital Covered Services

Surgery and any related diagnostic service received on the same day as the surgery

Radiation Therapy Treatments

Chemotherapy

Electroconvulsive Therapy

Renal Dialysis Treatments—if received in a hospital, a dialysis facility or in your home under the supervision of a hospital or dialysis facility

Diagnostic Service—when you are an outpatient and these services are related to surgery or medical care

Urgent Care

Emergency Accident Care

Emergency Medical Care

Bone Mass Measurement and Osteoporosis— Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

PHYSICIAN BENEFITS

For benefits to be available under this section, services must be medically necessary

Surgery

Benefits are available for surgery performed by a physician, dentist or podiatrist. However, for services performed by a dentist or podiatrist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under this Plan had they been performed by a physician. Benefits for oral surgery are limited to the following services:

excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

Anesthesia Services—if administered at the same time as a covered surgical procedure in a hospital or ambulatory surgical facility or by a physician other than the operating surgeon or by a certified registered nurse anesthetist. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or ambulatory surgical facility.

In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a hospital or ambulatory

Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

Assist at Surgery—when performed by a physician, dentist or podiatrist who assists the operating surgeon in performing covered surgery in a hospital or ambulatory surgical Facility. In addition, benefits will be provided for assist at surgery when performed by a registered surgical assistant or an advanced practice nurse. Benefits will also be provided for assist at surgery performed by a physician assistant under the direct supervision of a physician, dentist or podiatrist.

Sterilization Procedures (even if they are elective).

Medical Care

Benefits are available for Medical Care visits when:

you are an inpatient in a hospital, a skilled nursing facility, or substance use disorder treatment facility or

you are a patient in a partial hospitalization treatment program or coordinated home care program or

you visit your physician's office or your physician comes to your home.

Consultations

Your coverage includes benefits for consultations. The consultation must be requested by your physician and consist of another physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of hospital regulations or by a physician who also renders surgery or maternity service during the same admission.

Diabetes Self-Management Training and Education

Benefits will be provided for outpatient self-management training, education and medical nutrition therapy. Benefits will be provided if these services are rendered by a physician, or duly certified, registered or licensed health care professionals with expertise in diabetes management.

Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

Diagnostic Service—Benefits will be provided for those services related to covered surgery or medical care.

Emergency Accident Care

Emergency Medical Care

Electroconvulsive Therapy

Allergy Injections and Allergy Testing

Chemotherapy

Occupational Therapy

Benefits will be provided for occupational therapy when these services are rendered by a registered occupational therapist under the supervision of a physician. This therapy must be furnished under a written plan established by a physician and regularly reviewed by the therapist and physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for outpatient occupational therapy will be limited to a maximum of 60 visits per benefit period.

Physical Therapy

Benefits will be provided for physical therapy when rendered by a registered professional physical therapist under the supervision of a physician. The therapy must be furnished under a written plan established by a physician and regularly reviewed by the therapist and the physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for outpatient physical therapy will be limited to a maximum of 60 visits per benefit period.

Chiropractic and Osteopathic Manipulation—Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures. Your benefits for chiropractic and osteopathic manipulation will be limited to a maximum of 60 visits per benefit period.

Radiation Therapy Treatments

Speech Therapy

Benefits will be provided for speech therapy when these services are rendered by a licensed speech therapist or speech therapist certified by the American Speech and Hearing Association. Inpatient speech therapy benefits will be provided only if speech therapy is not the only reason for admission. Outpatient speech therapy benefits will be limited to a maximum of 60 visits per benefit period.

Clinical Breast Examinations—Benefits will be provided for clinical breast examinations when performed by a physician, advanced practice nurse or a physician assistant working under the direct supervision of a physician.

Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

Durable Medical Equipment—Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates and any other internal and permanent devices. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is

primarily and customarily used to serve a medical purpose.

Amino Acid-Based Elemental Formulas—Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when the prescribing physician has issued a written order stating that the amino acid-based elemental formula is medically necessary.

Orthotic Devices

Benefits will be provided for a supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs or replacement of the device because of a change in your physical condition, as medically necessary.

Outpatient Contraceptive Services

Outpatient contraceptive services means consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

Benefits for prescription contraceptive devices and implants will not be subject to a calendar year maximum.

Prosthetic Appliances

Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

they are required to replace all or part of an organ or tissue of the human body, or

they are required to replace all or part of the function of a non-function-ing or malfunctioning organ or tissue.

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required be-cause of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of temporomandibular joint dysfunction and related disorders, subject to specific limitations applicable to temporomandibular joint dysfunction and related disorders, and replacement of cataract lenses when a prescription change is not required).

Routine Pediatric Hearing Examination—Benefits will be provided for routine pediatric hearing examinations.

Pulmonary Rehabilitation Therapy—Benefits will be provided for outpatient cardiac/pulmonary rehabilitation programs provided within six months of a cardiac incident and outpatient pulmonary rehabilitation services.

OTHER COVERED SERVICES

The processing, transporting, storing, handling and administration of blood and blood components.

Private Duty Nursing Service—Benefits for private duty nursing service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private duty nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for private duty nursing service will not be provided due to the lack of willing or available non-professional personnel. Your benefits for private duty nursing Service are limited to a maximum of 60 visits per benefit period.

Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.

Dental accident care—Dental services rendered by a dentist or physician which are required as the result of an accidental injury.

Oxygen and its administration

Medical and surgical dressings, supplies, casts and splints

Hearing Aids—Benefits will be provided for hearing aids for children limited to two every 36 months.

Orthotics—Benefits will be provided for orthotics limited two foot orthotics per year.

Wigs—Benefits will be provided for wigs (also known as cranial prostheses) when your hair loss is due to chemotherapy, radiation therapy or alopecia. Benefits for wigs will be limited to a lifetime maximum of 2 wigs per member.

SPECIAL CONDITIONS AND PAYMENTS

There are some special things that you should know about your benefits should you receive any of the following types of treatments:

HUMAN ORGAN TRANSPLANTS

Your benefits for certain human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/ lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

— If both the donor and recipient have coverage each will have their benefits paid by their own program.

— If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits described in this SPD will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.

— If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described in this SPD will be provided for you. However, no benefits will be provided for the recipient.

Benefits will be provided for:

— Inpatient and outpatient covered services related to the transplant surgery.

— the evaluation, preparation and delivery of the donor organ.

— the removal of the organ from the donor.

— the transportation of the donor organ to the location of the transplant surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants will be provided as follows:

— Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/ kidney transplant is recommended by your physician, you must contact the Claim Administrator by telephone before your transplant surgery has been scheduled. The Claim Administrator will furnish you with the names of hospitals which have Claim Administrator approved human organ transplant programs. No benefits will be provided for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at any hospital that does not have a Claim Administrator approved human organ transplant program.

— If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this Plan, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than 50 miles from the hospital where the transplant will be performed.

— Benefits for transportation and lodging are limited to a combined maximum of $10,000 per transplant. The maximum amount that will be provided for lodging is $50 per person per day.

— In addition to the other exclusions of this SPD, benefits <u>will not be provided for the following</u>:

Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.

Travel time and related expenses required by a Provider.

Drugs which do not have approval of the Food and Drug Administration.

Storage fees.

Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.

Meals.

CARDIAC REHABILITATION SERVICES

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Claim Administrator approved programs. Benefits are avail-able if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft surgery, percutaneous transluminal coronary angioplasty, heart valve surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization.

PREVENTIVE CARE SERVICES

Benefits will be provided for the following Covered Services and will not be subject to any participant cost-sharing when such services are received in-network:

evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");

immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;

evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents;

with respect to women, such additional preventive care and screenings, not described above, as provided for in comprehensive guidelines supported by the HRSA.

For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

The preventive care services described above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the website at www.bcbsil.com or contact customer service at the toll-free number on your identification card.

Examples of covered services included are routine annual physicals, immunizations, well child(ren) care, cancer screenings, mammograms, bone density tests, screenings for prostate cancer and colorectal cancer, smoking cessation services and healthy diet counseling and obesity screenings/counseling.

Examples of covered immunizations included are Diphtheria, Haemophilus influenza type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, rubella, Tetanus, Varicella, Gardasil, and other immunization that is required by law for a child(ren). Allergy injections are not considered immunizations under this benefit provision.

Preventive services received from an out-of-network provider or other routine covered services not provided for under this provision will be subject to the Plan's regular cost-sharing, as described under the WELLNESS CARE provisions of this SPD.

WELLNESS CARE

Benefits will be provided for covered services rendered to you, even though you are not ill. Benefits will be limited to the following services:

Routine diagnostic medical procedures;

Routine EKG;

Routine x-ray;

Routine prostate and ovarian cancer screening;

Routine colorectal cancer screening x-ray.

The following are covered services when you receive them in a skilled nursing facility:

Bed, board and general nursing care.

Ancillary services (such as drugs and surgical dressings or supplies).

No benefits will be provided for admissions to a skilled nursing facility which are for the convenience of the patient or physician or because care in the home is not available or the home is unsuitable for such care.

Benefits will not be provided for covered services received in an uncertified skilled nursing facility.

You are entitled to benefits for 100 days of care in a skilled nursing facility per benefit period.

AMBULATORY SURGICAL FACILITY

Benefits for all of the covered services previously described in this SPD are available for outpatient surgery. In addition, benefits will be pro-vided if these services are rendered by an ambulatory surgical facility.

AUTISM SPECTRUM DISORDER(S)

Your benefits for the diagnosis and treatment of Autism Spectrum Disorder(s) are the same as your benefits for any other condition. Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder (a) by a physician or a psychologist who has determined that such care is medically necessary, or (b) by a certified, registered or licensed health care professional with expertise in treating Autism Spectrum Disorder(s) and when such care is determined to be medically necessary and ordered by a physician or a psychologist:

psychiatric care, including diagnostic services;

psychological assessments and treatments;

habilitative or rehabilitative treatments;

therapeutic care, including behavioral Speech, Occupational and Physical Therapies that provide treatment in the following areas: a) self-care and feeding, b) pragmatic, receptive and expressive language, c) cognitive functioning, d) applied behavior analysis (ABA), intervention and modification, e) motor planning and f) sensory processing.

HABILITATIVE SERVICES

Your benefits for habilitative services with congenital, genetic, or early acquired disorder are the same as your benefits for any other condition if all of the following conditions are met:

a physician has diagnosed the congenital, genetic, or early acquired disorder; and

treatment is administered by a licensed speech-language pathologist, audiologist, occupational therapist, physical therapist, physician, licensed nurse, optometrist, licensed nutritionist, or psychologist upon the referral of a physician; and

treatment must be medically necessary and therapeutic and not Investigational.

SUBSTANCE USE DISORDER REHABILITATION TREATMENT

Benefits for all of the covered services described in this SPD are available for substance use disorder rehabilitation treatment. In addition, benefits will be provided if these covered services are rendered by a behavioral health practitioner in a substance use disorder treatment facility. Inpatient benefits for these covered services will also be provided for substance use disorder rehabilitation treatment in a residential treatment center. Substance use

disorder rehabilitation treatment covered services rendered in a program that does not have a written agreement with the Claim Administrator or in a non-network provider facility will be paid at the non-network facility payment level.

DETOXIFICATION

Covered services received for detoxification are not subject to the substance use disorder treatment provisions specified above. Benefits for covered services received for detoxification will be provided under the HOSPITAL BENEFITS and PHYSICIAN BENEFITS section of this SPD, the same as for any other condition.

MENTAL ILLNESS AND SUBSTANCE USE DISORDER SERVICES

Benefits for all of the covered services described in this SPD are available for the diagnosis and/or treatment of a mental illness and/or substance use disorder. Treatment of a mental illness or substance use disorder is eligible when rendered by a behavioral health practitioner working within the scope of their license. Covered services rendered in a non-network facility will be paid at the non-network facility payment level.

BARIATRIC SURGERY

Benefits for covered services received for bariatric surgery will be provided through approved facilities only.

Benefits for the treatment of morbid obesity, including gastric bypass surgery, with the exception of lap band adjustments, are subject to a lifetime maximum of 1 procedure per covered member.

In certain circumstances, benefits for transportation and lodging will be provided up to a lifetime maximum of $10,000 dollars. The maximum amount that will be provided for lodging is $50 per person per day.

MATERNITY SERVICE

Your benefits for maternity service are the same as your benefits for any other condition and are available whether you have individual coverage or family coverage. Benefits will also be provided for covered services rendered by a certified nurse-midwife.

Benefits will be paid for covered services received in connection with both normal pregnancy and complications of pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have individual coverage. These covered services are: a) the routine inpatient hospital nursery charges and b) one routine inpatient examination and c) one inpatient hearing screening as long as this examination is rendered by a physician other than the physician who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have family coverage. You may apply for family coverage within 31 days of date of the birth. Your family coverage will then be effective from the date of the birth).

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your provider will not be required to obtain authorization from the Claim Administrator for prescribing a length of stay less than 48 hours (or 96 hours).

Your coverage also includes benefits for elective abortions if legal where performed.

INFERTILITY TREATMENT

Benefits will be provided the same as your benefits for any other condition for covered services rendered in connection with the diagnosis of infertility.

Infertility means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. The one year requirement will be waived if your physician determines a medical condition exists that makes conception impossible through unprotected sexual intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to

surgical removal due to a medical condition, or involuntary sterilization due to chemotherapy or radiation treatments; or, efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy.

Unprotected sexual intercourse means sexual union between a male and female without the use of any process, device or method that prevents conception including, but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures and includes appropriate measures to ensure the health and safety of sexual partners.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

Benefits for all of the covered services previously described in this SPD are available for the diagnosis and treatment of temporomandibular joint dysfunction and related disorders.

MASTECTOMY-RELATED SERVICES

Benefits for covered services related to mastectomies are the same as for any other condition. Mastectomy-related covered services include, but are not limited to:

Reconstruction of the breast on which the mastectomy has been per-formed;

Surgery and reconstruction of the other breast to produce a symmetrical appearance;

Inpatient care following a mastectomy for the length of time determined by your attending physician to be medically necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation and a follow-up physician office visit or in-home nurse visit within 48 hours after discharge; and

Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas.

The removal of breast implants when the removal of the implants is a medically necessary treatment for a sickness or injury. Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered. Cosmetic changes performed as reconstruction resulting from sickness or injury is not considered cosmetic surgery.

COVERED SERVICES IN A FOREIGN COUNTRY

Payment for covered services received in a foreign country will be provided at the payment level previously described in this booklet for an in-network provider.

HEARING CARE PROGRAM

Your coverage includes benefits for hearing care when you receive such care from a physician, otologist, audiologist or hearing aid dealer.

For hearing care benefits to be available, such care must be medically necessary.

Benefits will be provided under this Benefit Section for the following:

Audiometric Examination

Hearing Aid Evaluation

Conformity Evaluation

Hearing Aids

Benefits will be limited to covered service(s) of each type listed above per benefit period.

Benefits will not be provided for the following:

Audiometric examinations by an audiologist when not ordered by your physician within 6 months of such examination.

Medical or surgical treatment.

Drugs or other medications.

Replacement for lost or broken hearing aids, except if otherwise eligible under frequency limitations.

Hearing aids ordered while covered but delivered more than 60 days after termination.

HOSPICE CARE PROGRAM

Your hospital coverage also includes benefits for hospice care program service.

For benefits to be available you must have a terminal illness with a life expectancy of one year or less, as certified by your attending physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from hospice care program providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

Coordinated Home Care;

Medical supplies and dressings;

Medication;

Nursing Services - Skilled and non-Skilled;

Occupational Therapy;

Pain management services;

Physical Therapy;

Physician visits;

Social and spiritual services;

Respite Care Service.

The following services are not covered under the Hospice Care Program:

Durable medical equipment;

Home delivered meals;

Homemaker services;

Traditional medical services provided for the direct care of the terminal illness, disease or condition;

Transportation, including, but not limited to, Ambulance Transportation.

Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under this Hospice Care Program section, they may be covered services under other sections of this SPD.

WHAT'S NOT COVERED

While the Company medical program normally covers the treatments and services listed under "What's Covered," there are circumstances in which treatments and services are not eligible for coverage.

For specific information about whether something is covered, contact the appropriate member or customer services department of your medical program option at the telephone number provided with this summary or on your medical plan identification card. The medical program options generally do not cover the following:

- Any services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction, except as outlined in Preventive Care

Investigational Services and Supplies and all related services and supplies, except as may be provided under this SPD for a) the cost of routine patient care associated with

Investigational cancer treatment if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under this SPD if not provided in connection with a qualified cancer trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).Any portion of a charge for a service or supply that is in excess of the Network fee or the usual customary and reasonable charge as determined by the Claims Administrator.

- Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under Workers' Compensation laws.

- Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

- Any services or supplies provided for injuries sustained:

  - ✓ As a result of war, declared or undeclared, or any act of war; or

  - ✓ While on active or reserve duty in the armed forces of any country or international authority.

Custodial care service.

Long term care service.

Respite care service, except as specifically mentioned under the hospice care description.

Inpatient private duty nursing service.

Routine physical examinations, unless otherwise specified in this SPD.

Services or supplies received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of mental illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

Cosmetic surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.

Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.

Charges for failure to keep a scheduled visit or charges for completion of a claim form.

Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.

Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this SPD.

Blood derivatives which are not classified as drugs in the official formularies.

Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this SPD.

Treatment of flat foot conditions and the prescription of supportive devices for such

conditions and the treatment of subluxations of the foot.

Routine foot care, except for persons diagnosed with diabetes.

Immunizations, unless otherwise specified in this SPD.

Maintenance occupational therapy, maintenance physical therapy and Maintenance Speech Therapy, except as specifically mentioned in this SPD.

Maintenance care.

Speech therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation, except as may be provided under this SPD for autism spectrum disorder(s).

Habilitative services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.

Hearing aids or examinations for the prescription or fitting of hearing aids, unless otherwise specified in this SPD.

Diagnostic service as part of routine physical examinations or check- ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening, or similar procedures and studies, or tests which are investigational, unless otherwise specified in this SPD.

Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.

Wigs (also referred to as cranial prostheses), unless otherwise specified in this SPD.

Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this SPD.

Reversals of sterilization.

Services and supplies rendered or provided for the treatment of infertility including, but not limited to, hospital services, medical care, therapeutic injections, fertility and other drugs, surgery, artificial insemination and all forms of in-vitro fertilization.

Residential treatment centers, except for inpatient substance use disorders as specifically mentioned in this SPD.

- Any services or supplies that do not meet accepted standards of medical and/or dental practice.
- Any services or supplies not specifically defined as eligible expenses in this Plan.

PRESCRIPTION DRUG BENEFITS

You can fill prescriptions for yourself and your covered dependents through the prescription drug program provided through Express Scripts. The prescription drug benefits apply if you have elected any of the medical options (i.e., EPO, PPO or HDHP). Prescription drugs are covered under each plan as follows:

Medical Coverage

	EPO	HDHP (HSA Gold & Silver)	PPO
Retail Pharmacy (30-day supply) -Generic -Brand -Non-Formulary	$10 copay $30 copay $50 copay	You pay 20% (Gold) or 30% (Silver) after deductible	$10 copay 25% (min $30, max $75) 35% (min $50, max $110)
Maintenance Medications	100% of the retail cost (after second purchase)	100% of the retail cost (after second purchase)	100% of the retail cost (after second purchase)
Home Delivery (90-day supply) -Generic -Brand -Non-Formulary	$25 copay $60 copay $100 copay	You pay 20% (Gold) or 30% (Silver) after deductible	$25 copay 25% (min $75, max $150) 35% (min $125, max $225)

Copayment

Your copay will vary based on your medical option and how you purchase your prescription (retail versus home delivery). The copay will apply to a generic drug under the EPO and PPO options. Please note that if the retail cost of the drug is less than the copay that applies, you will only pay the retail cost of the drug.

Coinsurance

Similar to the basic medical portion of the plan, if you receive pharmacy services from an in-network provider, you may have to pay coinsurance.

Your coinsurance is the percentage you pay of the allowable amount. The allowable amount at non-participating pharmacies is basically the average wholesale price. That is, any one of the recognized published averages of the prices charged by wholesalers in the United States to pharmacies for the particular drug in question.

Allowable Amount

The allowable amount of non-participating pharmacy charges is based on the average wholesale price of the drug, which is any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a pharmacy.

Generic and Brand-Name Drugs

A generic drug is chemically identical to the brand-name prescription drug, but costs less. Like their brand-name counterparts, they are:

- Dispensed in the same dosage;
- Taken in the same way; and
- Packaged in the same unit strength.

If you request a brand-name drug when a generic drug is available, and if the brand-name drug is covered under your option, you pay the copayment (if applicable) plus the difference in cost between the brand-name drug and the generic drug.

About Brand Name Drugs (Formulary)

A drug formulary is a comprehensive list of recommended prescription medications that is created, reviewed, and continually updated by a team of physicians and pharmacists. The formulary contains a wide range of brand-name

products that are approved by the Food and Drug Administration. Your doctor can use this list to select medications for your health care needs, while helping you maximize your prescription drug benefit. The Express Scripts formulary excludes certain medications from coverage. For more information regarding the formulary exclusions and covered alternatives, visit Express-Scripts.com or download Express Scripts' smart phone application.

Using the Program

Retail Participating Pharmacy

For your convenience, you may use a retail participating pharmacy for medicines that need to be taken for just a short time. The Program has a network of pharmacies to serve you and your covered dependents. You can obtain up to a 30-day supply and refills at any participating pharmacy.

When filling your prescription at a retail participating pharmacy, simply present your prescription and your medical plan identification card to the pharmacist. Then, just pay the copayment (if applicable) at the time of purchase. You will have no further claims to file.

For a list of participating pharmacies or a copy of the prescription drug program's drug formulary, contact Express Scripts at 1-888-792-7276 or visit Express-Scripts.com.

Mail Order/Home Delivery Pharmacy

Alternatively, if you or a covered dependent takes long-term or ongoing medication, you can purchase a 90-day supply through the Program's mail order prescription service.

To order by mail, just send in a completed Prescription Mail Order Form and your doctor's prescription to the address on the order form along with a check for the copayment. If you are ordering your prescription by mail for the first time, you will also need to complete the member profile portion of the form and include it with your order. An order form will be included in your Express Scripts handbook that you receive with your prescription card and you will receive a new order form with each delivery.

You can order refills by phone at Express Scripts at 1-888-792-7276 or visit Express-Scripts.com to place your order. Allow two weeks for your first order to be processed and shipped. Refills will process and ship within 48 hours after your order is received. If you need to begin your medicine immediately, ask your doctor for a 30-day prescription to fill at any of the participating pharmacies.

Important Note: You will be required to purchase maintenance medications through the mail order program after you have two prescriptions filled at a retail pharmacy. You will pay the entire cost for a maintenance medication after the second purchase if you do not elect to have that prescription filled through home delivery.

Advanced Utilization Management Program (AUM)

The Advanced Utilization Management programs help you choose the safest, most cost-effective drug, and ensure that your use of the drug meets FDA guidelines.

- Prior Authorization ensures clinically appropriate use of medications.
- Step therapy encourages use of clinically effective, lower cost generic and preferred brand alternatives before higher cost medications.
- Drug Quantity Management aligns dispensing quantity with FDA-approved dosage guidelines and other supportive evidence.

If you are currently taking a medication that is affected by any of the AUM programs, you will receive advance notification from Express Scripts with information on what is required so that you do not have a gap in care.

What's Covered

The Program covers:

- Federal Legend Drugs
- Insulin
- Synagis

- Diabetic Supplies
- Respiratory Therapy Supplies
- Peak Flow Meters
- Certain preventive care drugs, as required by the Affordable Care Act.

What's Not Covered and Limitations

The benefits of the Prescription Drug Program are not available for:

- OTC's other than those listed in the Covered Section
- Abortifacients
- Depigmentation Products
- Photo Aged (Wrinkle) Medications
- Injectable Cosmetics (Botox Cosmetic)
- Hair Growth Agents
- Homeopathic Products
- Yohimbine
- Infertility
- Allergens
- Serums Toxoids and Vaccines other than HCR
- Diagnostic Testing and Imaging
- Nebulizers
- Durable Medical Equipment
- Medical Foods
- OTC Equivalent Medications

APPLYING FOR BENEFITS

Depending on which medical option you choose, and whether you receive your care from an EPO, a PPO network provider or a non-PPO network provider, you may not have to file a claim before the Plan pays medical benefits.

If your benefit claim is denied, you may appeal that decision. Read on for more details.

Payments made under the Plan to reimburse you for health care services will generally be made directly to the health care provider who furnishes the services (where you have used a Network Provider or otherwise assigned the right to seek reimbursement to your provider). You may not request the Claims Administrator to withhold proper payment to a provider on a claim after you have received the health care services. In other circumstances, the Claims Administrator may pay you directly for a claim. In this case, you are responsible for paying the health care provider.

Do You Need to File Claims?

The table below shows who needs to file claims for benefits

If You Are A…	Do You Need to File a Claim?
PPO or HDHP participant who receives services from an In-Network provider or pharmacy	No. Generally, claims are automatically filed for you.
PPO or HDHP participant who receives services from an Out-of-Network provider or pharmacy	Yes*

Medical Coverage

If You Are A…	Do You Need to File a Claim?
EPO participant who receives services from an In-Network provider or pharmacy	No
EPO participant who receives emergency services out-of-network	Yes*
EPO participant who receives non-emergency services out-of-network	N/A (non-emergency services received from out-of-network providers are not covered under the EPO option)

*Unless your provider submits the claim on your behalf.

How to File Claims

For all medical claims under the PPO or HDHP options, 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);
- Medicare Explanation of Benefits if the patient is age 65 or older; and
- Any other information requested on the claim form.

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.

For the PPO and HDHP options, medical claim forms are available from the Claims Administrator. Medical claims should be sent to the address at the back of this SPD or found on the Claims Administrator's website.

Covered expenses will be paid according to the Plan terms, however, payment of covered expenses may be coordinated with coverage you receive under another group health plan. See "Coordination of Benefits" in the Participation section of this handbook.

Timely Filing

You have up to 12 months from the date of service to file your claim for payment. Claims filed or received after 12 months are not eligible for payment. You should make every reasonable effort to file claims promptly after you incur services.

If a Claim is Denied

It's possible that your claim can be denied. Common reasons for denying a claim include:

- You use a provider that does not participate in your medical coverage option;
- You do not apply for benefits or provide the necessary claim information within the time allowed, benefit payments may be delayed or forfeited;
- Treatment is not medically necessary (if treatment is obtained without notifying the Claims Administrator); and/or

- If you abuse your medical benefits or deliberately and persistently violate provisions of the medical program.

If disagreements arise regarding your claim, every effort is made to resolve them quickly and informally. However, if that is not possible, formal procedures are in place so that you may appeal a decision on your claim. See “Claims Procedures” in the Participation section for details on the appeals process.

CONTENTS: DENTAL

Dental Coverage

Good health includes good dental hygiene. That's why the Company promotes preventive dental care and also provides benefits for corrective services through Delta Dental of Illinois or CarePlus. As you read about your coverage, keep in mind the following:

- Your dental care pay benefits for preventive, basic, major and orthodontic services.
- You may select coverage for yourself and your eligible dependents. You also may select no coverage. If you select no 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 section.
- The Delta Dental option is self-insured by the Company; the CarePlus option is fully-insured.
- Under the Delta Dental option, you and your covered dependents have the flexibility to choose your dentist.

A SNAPSHOT OF YOUR DENTAL COVERAGE OPTIONS

Here is a snapshot of the dental program options as of January 1, 2014.

	Delta Dental Program		**CarePlus**
	PPO or Premier In-Network	**Out-of-Network**	**In-Network Only**
Who Provides Care	Any dentist within the Delta PPO or Premier network	Any dentist who has not entered into an agreement with Delta Dental to provide services	Any dentist within the CarePlus network
Calendar-Year Maximum *(In-network and out-of network combined)*	$1,500/person	$1,500/person	$1,500/person
Annual Deductible *Individual* *Family*	 *$50* *$150*	 *$50* *$150*	 *$0/* *$0*
Preventive/Diagnostic Services (e.g., cleanings, exams, X-rays)	Covered at 100%. Deductible does not apply	Covered at 100% of MPA* charges Deductible does not apply	Covered at 100%
Basic Services (e.g., extractions, fillings, oral surgery)	Covered at 80%. Plus, you pay deductible	Covered at 80% of MPA* charges. Plus, you pay deductible	Covered at 100%
Major Services *(e.g., crowns, bridges, dentures)*	Covered at 50%. Plus, you pay deductible	Covered at 50% of MPA* charges. Plus, you pay deductible	Covered at 100%
Orthodontic Services *(dependent children up to age 19 only)*	Covered at 50% of network fee schedule Deductible does not apply $2,500 lifetime maximum	Covered at 50% of MPA* Deductible does not apply $2,500 lifetime maximum	100% of all charges in excess of $500

Dental Coverage

**Subject to maximum plan allowance (MPA) charge limitations. MPA is the maximum amount the plan will pay for a service, based on Delta Dental's schedules for similar services and supplies.*

How Your Dental Coverage Works

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

Types of Services Covered

Four main categories of services are covered: preventive/diagnostic care, basic, major and orthodontic care.

Choosing Whom To Cover

You may choose dental coverage for yourself and any one or more of your eligible dependents. The available coverage levels are:

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Employee + Family

See "Participation" for more details on who is considered an eligible dependent and when you can enroll yourself and/or your eligible dependents for dental coverage.

Maximum Annual Benefits

The Dental program has an annual maximum benefit of $1,500 for each covered person for eligible dental services, excluding orthodontic services. In other words, each covered person may receive up to $1,500 for covered expenses each calendar year. Only dental services that are medically necessary will be paid (except for specifically outlined preventive care).

Benefits payable for preventive care, basic restorative care, and major corrective care apply toward the maximum annual benefit.

DELTA DENTAL OPTION

PPO versus Premier Network Delta Dental Dentists

Both PPO and Premier Network Dentists are contracted with Delta Dental of Illinois. PPO dentists have agreed to reduced fees for their services, while Premier dentists have committed to charge no more than the Maximum Plan Allowance. In either case, these network dentists will not balance bill you for any amounts over the contracted rates.

Level of Benefits

If you receive your dental care from a network dentist, the percentage of benefits that is paid will be greater than with a non-network dentist. See the "Snapshot" chart in the beginning of this section for the specific percentages. Also, for network dentists, the percentage paid is based on the negotiated network fee. And, you do not have to pay for any expenses in excess of the negotiated rate for care received by a network dentist.

When you go to a non-network dentist, benefits are paid based on the "maximum plan allowance". You are responsible for any charges above the maximum plan allowance. The Claims Administrator for the dental program determines if all or part of a charge is above the maximum plan allowance.

Regardless of whether you select a network dentist or a non-network dentist, the Dental options have established an annual deductible to meet and other limitations.

The Annual Deductible

The deductible represents the amount you pay each year before benefits for certain services are paid. Whether you receive care by a network dentist or receive care by a non-network dentist, the annual deductible is $50 per person or $150 if you enroll your eligible dependents for coverage. Please note that no more than $50 in covered expenses incurred by a covered dependent is applied toward the annual family deductible. Once

you meet the family deductible, your remaining covered dependents do not have to meet their individual deductible amounts for the rest of that year.

Some services, however, do not require the deductible be met before benefits are paid, as shown below.

Category of Service	Meet Deductible?
Preventive/diagnostic Care	No
Basic Restorative	Yes
Major Corrective	Yes
Orthodontic Care	No

Lifetime Maximum Benefit

Orthodontic care is subject to a lifetime maximum benefit of $2,500 per covered person. This means that once benefits paid for orthodontic care reach these limits, no more benefits will be payable for orthodontic care.

What You Pay and What's Covered

The following describes what you pay for various Delta Dental services. It also describes any limits. The following is only a summary of covered services. For complete details, call the Claims Administrator's customer service department.

Preventive Care Services

Preventive care services are covered at 100% of the negotiated network fee for network services or at 100% of the usual, customary and reasonable charge for non-network services. Remember, you do not need to meet the annual deductible before benefits are paid. Preventive care services include:

- Oral exams during regular office hours (limited to twice each calendar year);
- Cleaning and scaling of teeth (limited to twice each calendar year) (With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, you will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year) (With an indicator for periodontal disease, you will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated below). (With an indicator for suppressed immune system conditions or cancer-related chemotherapy and/or radiation, you will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated below) (With an indicator for pregnancy, you will be eligible for one additional cleaning (prophylaxis or periodontal maintenance) during the time of pregnancy);
- Complete oral/periodontal evaluation of new or established patient (once per dentist);
- Fluoride treatments (limited to one course of treatment per year for dependent children under age 19);
- Space maintainers up to age 14 recementation of space maintainers (once per calendar year);
- Intra-oral – periapical radiographs;
- Full-mouth dental X-rays, panoramic x-ray and vertical bitewings, including panoramic x-ray in conjunction with any other x-ray, or any combination of intraoral x-rays on the same date for which the total approved amount equals or exceed the approved amount for a full-mouth x-ray (limited to once in any 36-month period);
- Bitewing X-rays, not including vertical bitewings (limited to twice each calendar year);
- Diagnostic casts: when rendered more than 30 days prior to definitive treatment;
- Pulp vitality tests (once per year);
- Palliative treatment;
- Sealants on first and second molars up to age 19;
- Consultations.

Dental Coverage

Basic Restorative Services

After you meet the annual deductible, 80% of the negotiated network fee for network services or 80% of the maximum plan allowance for non-network services are covered for the following basic restorative dental services.

- Amalgam and resin-based composite fillings (once per surface in a 12-month interval);
- Pulpal and root canal therapy (When endodontic therapy is performed on primary teeth, the level of benefits will be limited to that of a pulpotomy, except where radiographs indicate there is no permanent successor tooth and the primary tooth demonstrates sufficient intact root structure; retreatment of root canal therapy within 24 months of initial treatment is not a covered benefit; when incomplete endodontic therapy is billed because the patient has been referred to an endodontist for completion of endodontic treatment, the level of benefits will be limited to that of a pulpal debridement; pulpal therapy (resorbable filling) is a covered dental benefit once per tooth per lifetime);
- Gingivectomy or gingivoplasty; gingival flap procedure;
- Clinical crown lengthening - hard tissue;
- Osseous surgery (including flap entry and closure);
- Guided tissue regeneration, per site: only when performed in association with natural teeth;
- Bone replacement and soft tissue grafts;
- Periodontal scaling and root planning (Periodontal therapy includes treatment for diseases of the gums and bone supporting the teeth once per quadrant in any 24-month interval);
- Full mouth debridement to enable comprehensive evaluation and diagnosis: once per lifetime;
- Periodontal maintenance: twice per calendar year (With an indicator for diabetes, high risk cardiac conditions, or kidney failure or dialysis conditions, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year. With an indicator for periodontal disease, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated in this schedule of dental benefits. With an indicator for suppressed immune system conditions or cancer-related chemotherapy and/or radiation, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated in this schedule of dental benefits. With an indicator for pregnancy, the enrollee will be eligible for one additional cleaning (prophylaxis or periodontal maintenance) during the time of pregnancy);
- Full mouth debridement to enable comprehensive evaluation and diagnosis: once per lifetime;
- Deep sedation/general anesthesia: when provided by a dentist in conjunction with Oral Surgery (surgical procedures) other than simple extractions;
- Simple extractions;
- Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth;
- Removal of impacted tooth – soft tissue;
- Removal of impacted tooth – partially bony;
- Removal of impacted tooth – completely bony;
- Tooth reimplantation/stabilization of accidentally evulsed or displaced tooth and/or alveolus;
- Surgical access of an unerupted tooth;
- Biopsy of oral tissue; brush biopsy;
- Alveoloplasty - per quadrant;
- Vestibuloplasty - ridge extension;

- Surgical excision of soft tissue lesions;
- Surgical excision of intra-osseous lesions;
- Other covered surgical/repair procedures: removal of exostosis, torus palatinus or torus mandibularis; incision and drainage of abscess - intraoral soft tissue; frenulectomy or frenuloplasty; excision of hyperplastic tissue or pericoronal gingiva; surgical reduction of osseous or fibrous tuberosity.

Major Corrective Services

After you meet the annual deductible, 50% of the negotiated network fee for network services or 50% of the maximum plan allowance for non-network services are covered for the following major corrective dental services.

- Removable Prosthodontic Services
  - Complete and partial dentures (When a fixed partial denture is requested or placed and three or more teeth are missing in a dental arch, the level of benefits will be limited to that of a removable partial denture. The placement of any additional appliance in the same arch within 60 months following placement of the initial appliance is not a covered benefit);
  - Adjustments to complete and partial dentures;
  - Repairs to complete and partial dentures;
  - Replace missing or broken teeth;
  - Add tooth or clasp to existing partial denture;
  - Replace all teeth and acrylic on cast metal Framework;
  - Denture rebase: once in a 24-month interval;
  - Denture reline: once in a 24-month interval.
- Fixed Prosthodontic Services
  - Pontics (When the edentulous space between teeth exceeds 100% of the size of the original tooth, the level of benefits will be limited to that of one pontic per missing tooth);
  - Fixed partial denture retainers - inlays/onlays (inlays/onlays placed as abutments, i.e., to retain or support fixed partial dentures);
  - Fixed partial denture retainers – crowns (crowns placed as abutments, i.e., to retain or support fixed partial dentures)
  - Recement fixed partial denture once in a lifetime
  - Cast or prefabricated post and core; core build-up
- When the edentulous space between teeth exceeds 100% of the size of the original tooth, the level of benefits will be limited to that of one pontic per missing tooth.
- When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the level of benefits will be limited to that of a removable partial denture.
- If, in the construction of a prosthodontic appliance, personalized or special techniques including, but not limited to, tooth supported dentures, precision attachments or stress breakers, are elected, the level of benefits will be limited to that of a conventional prosthodontic appliance.
- When a porcelain/ceramic inlay is requested or placed as an abutment (i.e., to retain or support a fixed partial denture), the level of benefits will be limited to that of a cast metal inlay.
- Implants.

Orthodontic Care

Orthodontic care for children is covered at 50% of the negotiated network fee for network services, and 50% of usual, customary and reasonable charges for non-network services. You do not have to meet the deductible for these covered

services to be paid, but there is the lifetime maximum benefit of $2,500 for each covered person.

Orthodontic services include treatment for the correction of abnormalities in the positioning and relationship of teeth (malocclusion).

Payment for orthodontic services are made on a monthly basis. Payments for treatments begun before coverage begins shall start with the first month after coverage is effective. Payments for treatments in process shall end in the month coverage terminates.

Please note that x-rays and space maintainers are covered as preventive care and paid at that level.

Pretreatment Review

If your dentist recommends a dental treatment that is expected to cost more than $300, you should have your dentist submit a treatment plan to the Claims Administrator before dental work begins. The Claims Administrator will review your treatment plan and will let you and your dentist know what will be covered under the Traditional Group Dental option and how much you have to pay. This is called a pretreatment review.

To start the pretreatment review process, ask your dentist to contact the Claims Administrator.

The Claims Administrator will send you and your dentist a summary of the benefits payable or suggest an alternate procedure. If the dentist changes the treatment after you submit a pretreatment plan, claim payments are adjusted accordingly. If the treatment plan is changed in a major way, your dentist may submit the revised plan for another pretreatment review.

If you decide not to undergo a pretreatment review, you are reimbursed for the dental charges based on the information the dentist provides after the work is completed. This could result in lower benefits if the Claims Administrator would have recommended an alternate procedure.

Alternate Treatment Rule

If more than one service can be used to treat a covered person's dental condition, the Claims Administrator may decide to authorize coverage only for an alternate treatment, which is a less costly covered service, provided that all of the following conditions are met:

- The service is listed as a covered dental service;
- The service selected is deemed by the dental profession to be an appropriate method of treatment; and
- The service selected meets broadly accepted national standards of dental practice.

If treatment is being given by a participating dental provider and the covered person asks for a more costly covered service than that for which coverage is approved, the specific copayment or coinsurance for such service will consist of:

- The copayment or coinsurance for the less costly approved service, plus
- The difference in cost between the less costly approved service and the more costly covered service.

Replacement Rule

The replacement of, addition to, or modification of existing dentures, crowns, cast or processed restorations, removable bridges, or fixed bridgework is covered only if one of the following conditions is met:

- The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. Dental coverage under the applicable option must have been in force for the covered person when the extraction took place; or
- The existing denture, crown, cast or processed restoration, removable bridge, or bridgework cannot be made serviceable, and was installed at least five years before its replacement.

What's Not Covered

The dental services and supplies listed below are not covered by the Delta Dental coverage options.

Dental Coverage

This list is only a summary; if you have questions about a specific dental service, treatment, or supply, call the Claims Administrator's member services department.

EXCLUSIONS THAT APPLY TO DIAGNOSTIC SERVICES:

- Pulp vitality tests billed in conjunction with any service except for an emergency exam or palliative treatment are not a covered benefit.

EXCLUSIONS THAT APPLY TO PREVENTIVE SERVICES:

- Recementation of a space maintainer within six months of initial placement is not a covered benefit.

EXCLUSIONS THAT APPLY TO RESTORATIVE SERVICES:

- Fillings are not a covered benefit when crowns are allowed for the same teeth.

- Replacement of any existing cast restoration (crowns, onlays, ceramic restorations) with any type of cast restoration within 60 months following initial placement of existing restoration is not a covered benefit.

- Replacement of a stainless steel crown with any type of cast restoration is not a covered benefit by the same office within 24 months following initial placement.

- A cast restoration is a covered benefit only in the presence of radiographic evidence of decay or missing tooth structure. Restorations placed for any other purpose, including, but not limited to, cosmetics, abrasion, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformations of teeth, or the anticipation of future fractures, are not a covered benefit.

- When there is radiographic evidence of sufficient vertical height (more than three millimeters above the crestal bone) on a tooth to support a cast restoration, a crown build-up is not a covered benefit.

- The repair of any component of a cast restoration is not a covered benefit.

- Recementation of inlays, onlays, partial coverage restorations, cast and prefabricated posts and cores and crowns by the same office within six months of initial placement is not a covered benefit.

- Additional procedures to construct a new crown under the existing partial denture framework within six months following initial placement is not a covered benefit.

- When a sedative filling is requested or placed on the same date as a permanent filling, the sedative filling is not a covered benefit.

EXCLUSIONS THAT APPLY TO ENDODONTIC SERVICES:

- When a benefit has been issued for endodontic services, retreatment of the same tooth within two years is not a covered benefit.

- Endodontic procedures performed in conjunction with complete removable prosthodontic appliances are not a covered benefit.

EXCLUSIONS THAT APPLY TO PERIODONTIC SERVICES:

- Guided tissue regeneration billed in conjunction with implantology, ridge augmentation/sinus lift, extractions or periradicular surgery/apicoectomy is not a covered benefit.

- Crown lengthening or gingivoplasty, if not performed at least four weeks prior to crown preparation, is not a covered benefit.

- Bone replacement grafts performed in conjunction with extractions or implants are not a covered benefit.

- Periodontal splinting to restore occlusion is not a covered benefit.

EXCLUSIONS THAT APPLY TO PROSTHODONTIC SERVICES:

- Replacement of any existing prosthodontic appliance (cast restorations, fixed partial dentures, removable partial dentures, complete denture) with any prosthodontic appliance within 60 months following initial placement of existing appliance is not a covered benefit.

- When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the fixed partial denture is not a covered benefit.

- Reline or rebase of an existing appliance within six months following initial placement is not a covered benefit.

- Fixed or removable prosthodontics for a patient under age 16 is not a covered benefit.

- Tissue conditioning is not a covered benefit.

- When the edentulous (toothless) space between teeth is less than 50% of the size of the missing tooth, a pontic is not a covered benefit.

EXCLUSIONS THAT APPLY TO ORAL SURGERY:

- Mobilization of an erupted or mal-positioned tooth to aid eruption or placement of a device to facilitate eruption of an impacted tooth performed in conjunction with other oral surgery is not a covered benefit.

GENERAL EXCLUSIONS THAT APPLY TO ALL PROCEDURES:

Coverage is NOT provided for:

- Services compensable under Worker's Compensation or Employer's Liability laws.

- Services provided or paid for by any governmental agency or under any governmental program or law, except as to charges which the person is legally obligated to pay. This exception extends to any benefits provided under the U.S. Social Security Act and its Amendments.

- Services performed to correct developmental malformation including, but not limited to, cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis and congenitally missing teeth. This exclusion does not apply to newborn infants.

- Services performed for purely cosmetic purposes, including, but not limited to, tooth-colored veneers, bonding, porcelain restorations and microabrasion. Orthodontic care benefits shall fall within this exclusion unless such benefits are provided by endorsement and a participant elects family coverage. In no event will a Covered Individual age 19 or over be able to receive orthodontic care benefits.

- Charges for services completed prior to the date the person became covered under this program.

- Services for anesthetists or anesthesiologists.

- Temporary procedures.

- Any procedure requested or performed on a tooth when radiographs indicate that less than 40% of the root is supported by bone.

- Services performed on non-functional teeth (second or third molar without an opposing tooth).

- Services performed on deciduous (primary) teeth near exfoliation.

- Drugs or the administration of drugs, except for general anesthesia.

- Procedures deemed experimental or investigational by the American Dental Association, for which there is no procedure code, or which are inconsistent with Current Dental Terminology coding and nomenclature.

- Services with respect to any disturbance of the temporomandibular joint (jaw joint).

- Procedures that Delta Dental considers to be included in the fees for other procedures. For such procedures, a separate payment will not be made by this group dental plan. A Dentist in the Delta Dental PPO or Delta Dental Premier network may not bill the patient for such procedures.

- The completion of claim forms and submission of required information, not otherwise covered, for determination of benefits.

- Infection control procedures and fees associated with compliance with Occupational Safety and Health Administration (OSHA) requirements.

- Broken appointments.

- Services and supplies for any illness or injury occurring on or after the covered individual's effective date of coverage as a result of war or an act of war.

- Services for, or in connection with, an intentional self-inflicted injury or illness while sane or insane, except when due to domestic violence or a medical (including both physical and mental) health condition.

- Services and supplies received from either a covered individual's or covered individual's spouse's relative, any individual who ordinarily resides in the covered individual's home or any such similar person.

- Services for, or in connection with, an injury or illness arising out of the participation in, or in consequence of having participated in, a riot, insurrection or civil disturbance or the commission of a felony.

- Charges for services for inpatient/outpatient hospitalization.

- Services or supplies for oral hygiene or plaque control programs.

- Services or supplies to correct harmful habits.

CAREPLUS OPTION

If you select the CarePlus Dental option, you will have to use a CarePlus network dentist in order to receive benefits.

What's Covered

The following describes what you pay for various CarePlus services. It also describes any limits. The following is only a summary of covered services. For complete details, call the Claims Administrator's customer service department.

Preventive

- Periodic oral examination – 2 per year
- Limited oral evaluation—problem focus
- Oral evaluation for patient <3 years w/counseling w/primary caregiver
- Comprehensive oral evaluation
- Intraoral-complete series w/bitewings
- Intraoral-periapical-first film
- Intraoral-periapical-each additional film
- Bitewing-single film
- Bitewing-two films – 2 per year
- Bitewing-four films – 2 per year
- Vertical bitewings
- Panoramic film
- Pulp vitality tests
- Diagnostic casts
- Prophylaxis-adult – 2 per year
- Prophylaxis-child – 2 per year
- Topical application fluoride w/o prophy child—Thru Age 15
- Nutritional counseling
- Oral hygiene instruction
- Sealant per tooth – Thru Age 15
- Space maintainer—fixed—unilateral
- Space maintainer—fixed—bilateral
- Recementation of space maintainer

Restorative

- Amalgam—one surface, primary or permanent
- Amalgam—two surfaces, primary or permanent

Dental Coverage

- Amalgam—three surfaces, primary or permanent
- Amalgam—four or more surfaces, primary or permanent
- Resin—one surface, anterior
- Resin—two surfaces, anterior
- Resin—three surfaces, anterior
- Resin—four or more surfaces, anterior incisal angle
- Resin-based composite crown, anterior
- Resin-based composite - one surface, posterior
- Resin-based composite - two surfaces, posterior
- Resin-based composite - three surfaces, posterior
- Resin-based composite - four or more surfaces, posterior
- Crown—porcelain/ceramic substrate
- Crown—porcelain fused to noble metal
- Crown—full cast noble metal
- Recement inlay
- Recement crown
- Prefabricated stainless steel crown—primary tooth
- Prefabricated stainless steel crown—permanent tooth
- Prefabricated resin crown
- Prefabricated stainless steel crown w/resin window
- Prefabricated esthetic coasted stainless steel crown – primary tooth
- Sedative filling
- Core build-up w/pins
- Pin retention/tooth in addition to crown
- Cast post and core in addition to crown
- Prefabricated post and core in add to crown
- Post removal not in conjunction w/endodontic therapy
- Labial veneer (laminate) chair side
- Crown repair

Endodontics

- Pulp cap—direct w/o final restoration
- Pulp cap—indirect w/o final restoration
- Therapeutic pulpotomy w/o final restoration
- Pulpal debridement, primary and permanent tooth
- Pulpal therapy, anterior primary tooth
- Pulpal therapy, posterior primary tooth
- Anterior w/o final restoration
- Bicuspid w/o final restoration
- Molar w/o final restoration
- Incomplete endodontic therapy procedure
- Retreat Anterior Root Canal
- Retreat Bicuspid Root Canal
- Retreat Molar Root Canal
- Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.). If over age 11 no benefit if performed within 12 months of root canal.

Dental Coverage

- Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.). If over age 11 no benefit if performed within 12 months of root canal.
- Apexification/recalcification – final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.). If over age 11 no benefit if performed within 12 months of root canal.
- Apicoectomy/Periradicular—anterior
- Apicoectomy/Periradicular – bicuspid (first root)
- Apicoectomy/Periradicular – molar (first root)
- Apicoectomy/Periradicular (add'l root)
- Retrograde filling—per root
- Root amputation—per root
- Hemisection w/o root canal therapy

Periodontics

- Periodontic consultation
- Gingivectomy/gingivoplasty/four or more teeth per quadrant
- Gingivectomy/gingivoplasty/one to three teeth per quadrant
- Anatomical crown exposure – one to three teeth per quadrant
- Gingival flap procedure w/root plan/four or more teeth per quadrant
- Gingival flap procedure w/root plan/one to three teeth per quadrant
- Clinical crown lengthening –hard tissue
- Osseous surgery w/flap entry/four or more teeth per quadrant
- Osseous surgery w/flap entry/one to three teeth per quadrant
- Bone replacement graft – first site in quadrant
- Bone replacement graft – each additional site in quadrant
- Guided tissue regeneration – resorbable barrier, per site
- Guided tissue regeneration – nonresorbable barrier, per site (includes membrane removal
- Pedicle soft tissue graft procedure
- Free soft tissue graft procedure
- Subepithelial connective tissue graft procedures, per tooth
- Distal or proximal wedge procedure
- Soft tissue allograft
- Provisional splinting – intracoronal
- Provisional—splinting—extra
- Scaling and root planing/four or more teeth per quadrant – one per 24 Mo.
- Scaling and root planing/one to three teeth per quadrant – one per 24 Mo.
- Full mouth debridement – one per 18 Mo.
- Localized delivery of chemo agents
- Periodontal maintenance procedure – one per 12 Mo. Only

Prosthodontics - Removable

- Complete denture—maxillary
- Complete denture—mandibular
- Immediate denture—maxillary
- Immediate denture—mandibular
- Maxillary partial denture—resin base
- Mandibular partial denture—resin base

Dental Coverage

- Maxillary partial denture—cast metal frame
- Mandibular partial denture—cast metal frame
- Maxillary partial denture – flexible base
- Mandibular partial denture – flexible base
- Removable unilateral partial denture
- Adjust complete denture—maxillary
- Adjust complete denture—mandibular
- Adjust partial denture—maxillary
- Adjust partial denture—mandibular
- Repair broken denture
- Replace missing/broken teeth – per tooth
- Repair resin denture base
- Repair cast framework
- Repair or replace broken clasp
- Replace broken teeth – per tooth
- Add tooth to existing partial denture
- Add clasp to existing partial denture
- Reline complete maxillary denture (chair)
- Reline complete mandibular denture (chair)
- Reline maxillary partial denture (chair)
- Reline mandibular partial denture (chair)
- Reline complete maxillary denture (lab)
- Reline complete mandibular denture (lab)
- Reline maxillary partial denture (lab)
- Reline mandibular partial denture (lab)
- Tissue conditioning, maxillary
- Tissue conditioning, mandibular
- CU-SIL Attachment, mandibular)
- Silicone soft liner

Prosthodontics - Fixed

- Pontic—cast noble metal
- Pontic—porcelain fused to noble metal
- Pontic – porcelain/ceramic
- Crown – porcelain/ceramic
- Crown—porcelain fused to noble metal
- Crown—full cast noble metal
- Recement fixed bridgework
- Stress breaker
- Cast post and core in addition to fixed
- Prefab post and core in addition to fixed
- Core build-up for bridge, including any pins
- Fixed bridgework repair

Oral Surgery

- Extraction, coronal remnants – deciduous tooth
- Extraction, erupted tooth or exposed root
- Surgical removal of erupted tooth
- Removal of impacted tooth—soft tissue
- Removal of impacted tooth—partial bony
- Removal of impacted tooth-comp bony
- Removal of impacted tooth—comp bony/comp
- Surgical removal of residual tooth roots
- Oral antral fistula closure (medical)

- Tooth reimplantation/stabilization
- Surgical access of an unerupted tooth
- Placement of device to facilitate eruption of impacted tooth
- Biopsy of oral tissue—hard
- Biopsy of oral tissue—soft
- Brush biopsy
- Trannseptal fiberotomy
- Alveoloplasty in conjunction w/extractions four more teeth per quad
- Alveoloplasty in conjunction w/extractions one to three teeth per quad
- Alveoloplasty not in conjunction w/extractions four or more teeth per quad
- Alveoloplasty not in conjunction w/extractions one to three teeth per quad
- Vestibuloplasty ridge ext
- Vestibuloplasty ridge ext complete
- Removal of exostosis max or man
- Removal of torus palatinus
- Removal of torus mandibularis
- Surgical reduction of osseous tuberosity
- I&D abscess—intraoral soft tissue
- Suture simple 5 cm (w/trauma)
- Bone replacement graft for ridge preservation – per site
- Frenulectomy—separate procedure
- Excision of hyperplastic tissue/arch
- Excision of pericoronal gingival
- Surgical reduction of fibrous tuberosity

Adjunctive Services

- Palliative—Emergency treatment dental pain—minor
- Local anesthesia not in conjunction with operative or surgical procedures
- Local anesthesia in conjunction with operative or surgical procedures
- Deep sedation/general anesthesia – first 30 minutes
- Deep sedation/general anesthesia – each additional 15 minutes
- Inhalation of nitrous oxide/analgesia – DDS required
- Intravenous conscious sedation/analgesia – first 30 minutes when Medically Necessary
- Intravenous conscious sedation/analgesia – each additional 15 minutes when Medically Necessary
- Consultation—per session
- Office visit for observation
- Other drugs and/or medicaments
- Application of desensitizing medicaments
- Occlusal adjustment – limited

What's Not Covered

The dental services and supplies listed below are not covered by the CarePlus coverage options. This list is only a summary; if you have questions about a specific dental service, treatment, or supply, call the Claims Administrator's member services department.

1. Dental Services not specifically described above.

2. Dental Services with respect to congenital malformations or that are primarily for cosmetic or

esthetic purposes, except congenitally missing teeth.

3. Any duplicate prosthetic device or any other duplicate appliance, except as otherwise provided.

4. The replacement of a lost or stolen prosthetic device or appliance, except as otherwise provided.

5. The replacement of an orthodontic appliance, except as otherwise provided.

6. Treatment of temporomandibular joint (TMJ) dysfunction.

7. Gold foil, gold or precious metal restorations, except when used as necessary functional material.

8. Implants or transplants.

9. Dental service or emergency service:

(a) That would be furnished, without charge, to You by any person or entity other than CarePlus;

(b) That you would be entitled to have furnished or paid for, fully or partially, under any law, regulation or agency of any government;

(c) That you are entitled or would be entitled if you were enrolled, to have furnished or paid for under any voluntary medical or dental insurance plan established by any government if this Plan coverage was not in effect;

(d) To the extent that Medicare is your primary payor, which it is, except where Medicare is secondary by law. Where Medicare is primary payor, no benefits are available to the extent you would have been entitled to Medicare benefits had you enrolled in Medicare or complied with Medicare requirements.

(e) For, or resulting from injuries, disease or conditions for which you receive, or are the subject of, any award or settlement under a Workers Compensation Act or any Employer Liability Law; or

(f) Rendered or furnished after the date you cease to be covered under the Plan, unless your cessation of coverage is not due to a termination of the contract with CarePlus, in which case coverage may continue for You as long as the contract with CarePlus remains in force for:

(i) Procedures (other than prosthetic services) commenced prior to, and completed in one visit within thirty-one (31) days following termination of coverage; and

(ii) Prosthetic devices that are ordered and fitted prior to, and completed within sixty (60) days following, termination of coverage.

(g) Provided at a location other than the offices of the primary provider except for emergency service.

10. Hospital or physician services of any kind whether or not related to covered dental services.

11. Dental service and emergency service resulting from diseases contracted or injuries sustained as a result of war, declared or undeclared, enemy action or action of the Armed Forces of the United States, or its allies, or while serving in the Armed Forces of any country; or any illness or injury occurring after the effective date of this Contract and caused by atomic explosion whether or not the result of war.

12. Reimbursement to the you or any dental office for the cost of dental services provided by dentists other than the primary provider, unless expressly authorized in writing by the primary provider or due to an emergency.

13. Out of area services, unless due to an emergency and then covered only to the extent of the emergency service benefit shown in the benefit schedule.

14. Dental service and emergency service received from a dental or medical department maintained on behalf of an employer, a mutual benefit association, a labor union, academic institution, trustee or similar person or group.

15. Replacement of an existing removable denture, full denture, crown or fixed bridge by a new removable partial denture, full denture, crown or a fixed bridge if the existing appliance was provided in the previous five years. The five-year period will

be measured from the date on which the existing appliance was last supplied.

16. If a satisfactory result can be achieved by a conventional removable partial denture in the case of bilateral edentulous areas, but the participant selects a more complicated treatment (precision attachments or fixed bridgework), benefits shall be limited to the appropriate procedures necessary to eliminate oral disease and restore missing teeth. The balance of the cost for the more elaborate selected procedure will be the responsibility of the participant.

17. Services or supplies for personalization or characterization of dentures or bridges.

18. Crowns to restore diseased or broken teeth when the tooth can be restored by a conventional type filling.

19. Any expense arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which:

(a) Benefits are provided or payable under any Workers' Compensation, Employer Liability Law, or Occupational Disease Act or Law; or

(b) You would have been eligible for benefits under any Workers' Compensation, Employer Liability Law or Occupational Disease Act or Law had You applied for such coverage;

20. Any service related to:

(a) Altering vertical dimension;

(b) Restoration of occlusion;

(c) Splinting teeth including multiple abutments or any service to stabilize periodontally weakened teeth;

(d) Replacing tooth structures as a result of abrasions, attrition, or erosion; or

(e) Bite registration or bite analysis.

21. Missed appointment charges.

APPLYING FOR BENEFITS

Depending on which dentist you use, you may not have to file a claim for benefits. If your benefit claim is denied, you may appeal that decision. Read on for more details.

Do You Need to File Claims?

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

If You Are A …	Do You Need to File a Claim?
Use an in-network dentist	No
Use an out-of-network dentist	Yes

Filing a Claim

Your claims are processed by the Claims Administrator for the Dental options. Be sure to file claims within 90 days after dental services are provided. However, you have up to one year to file a claim if you cannot, through no fault of your own, file a claim within the 90-day period. To file a dental claim, contact the Claims Administrator.

If a Claim is Denied

It's possible that your claim can be denied. If disagreements arise regarding your claim, every effort is made to resolve them quickly and informally. However, if that is not possible, formal procedures are in place so that you may appeal a decision on your claim. See "Claims Procedures" in the Participation section for details on the appeals process.

CONTENTS: VISION

Vision Coverage

Through the Company, you can elect vision coverage as part of your overall health and wellness program for you and your eligible dependents. As you read about your coverage, keep the following in mind:

- The Company pays for a Basic Vision plan for you and your dependents. Alternately, you may elect a Buy-Up Vision plan that provides for greater benefits.
- The vision program is designed to cover Basic Vision needs, such as routine eye exams and lenses, and is provided through VSP®, an independent vision care company. The program is not designed to cover cosmetic eyewear, or medical or surgical treatment of eyes.
- In the Buy-Up Vision option, you may select coverage for yourself and your eligible dependents.
- You also may select no coverage for either the Basic or Buy-Up Vision. If you select no coverage, you are not eligible for benefits for the under that Vision program described in this section.
- You can receive services from a doctor of your choice. However, if you go to a VSP network doctor, you will pay less for your exam and receive discounts on services and prescription eyewear. VSP network doctors will also file the claim for benefits on your behalf. VSP network doctors are private practice vision care professionals who have contracted with VSP to provide services for pre-negotiated, discount fees.
- If you choose a non-VSP provider, your provider is not obligated to give you a discount on his services or the purchase of prescription eyewear. And, you pay for services at the time you receive them and then file a claim for benefits.

A SNAPSHOT OF YOUR VISION COVERAGE

How VSP pays benefits and the amount of benefits it pays depends on the care you receive and where you receive it. Here is a snapshot of your vision care benefits:

Covered Services	**Basic Vision Plan (VSP)**		**Buy-Up Vision Plan (VSP)**	
	VSP Provider	**Non-VSP Provider**	**VSP Provider**	**Non-VSP Provider**
Who Provides Care	A VSP Provider	Any provider	A VSP provider	Any provider
Eye Examinations *(one every 12 months)*	You Pay a $20 copay	You will be reimbursed up to $45	You pay a $20 copay	You will be reimbursed up to $45
Materials *Standard Lenses-- Single Vision, Bifocal or Trifocal* (*once every 12 months only when a complete pair of glasses is purchased*)	*You receive a 20% discount*	*No coverage*	*You pay a $20 copay; discount off other lens options*	*You pay any amount above $30 for single vision; $50 for bifocal; $65 for trifocal; $50 for progressive*

Vision Coverage

Covered Services	Basic Vision Plan (VSP)		Buy-Up Vision Plan (VSP)	
	VSP Provider	**Non-VSP Provider**	**VSP Provider**	**Non-VSP Provider**
Frames *(once every 24 months only when a complete pair of glasses is purchased)*	*You receive a 20% discount (excluding Costco)*	*No coverage*	*Allowance up to $130 ($70 at Costco); 20% off balance (other than Costco)*	*You will be reimbursed up to $70*
Contact Lenses *(once every 12 months)*	*You receive a 15% discount on fitting and evaluation*	*No coverage*	*Allowance up to $130; $60 maximum copay for standard and premium contact lens fitting and evaluation*	*You will be reimbursed up to $105*
Cosmetic Options	No coverage	No coverage	You receive a 20% discount on additional glasses and sunglasses	No coverage
Laser VisionCare	You receive an average 15% discount (or 5% off promotional price) at contracted facilities	No coverage	You receive an average 15% discount (or 5% off promotional price) at contracted facilities	No coverage

HOW YOUR VISION COVERAGE WORKS

Under the vision programs, you may use any licensed vision care provider. But, to get the biggest possible benefit from the vision program, you will need to go to a VSP network doctor for care.

VSP network doctors are located right where you need them – close to work, home and shopping centers. They provide top quality care and offer a wide selection of frames to choose from – all at one convenient location.

Finding and Using a VSP Network Doctor or Retail Chain Affiliate Provider

When you or a covered dependent needs vision care, call VSP at 800.877.7195 and request a directory of VSP network doctors or retail chain affiliate providers in your area. Or, you can access VSP via the internet at www.vsp.com.

A VSP network doctor or retail chain affiliate provider is any optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide eyewear who has contracted with VSP.

With VSP, you don't need an identification card. When you make an appointment with the VSP network doctor you selected, identify yourself as a

VSP member. Your doctor and VSP will handle the rest. If you do not identify yourself as a VSP member, then benefits may be provided as if you used a non-VSP provider.

At the time you receive services or purchase eyewear, you pay the required copay plus you pay for any services and eyewear that VSP does not cover. VSP simply pays the covered amounts for the vision care you receive directly to the VSP network doctor. Using a VSP doctor means you don't have to file claim forms. Plus, you don't have to file claim forms. You pay a copay for eye exams and for services and eyewear that cost more than VSP's benefit amount.

Under the Basic Vision plan, if you use a VSP network doctor, you receive certain value added discounts, which can include:

- A 20% savings on lens extras, such as scratch resistant and anti-reflective coatings and progressives;
- A 15% discount off the cost of elective contact lens exam (evaluation and fitting). The discount applies to the VSP network doctor's usual and customary fees. The contact lens exam ensures proper fit of contacts and is in addition to your routine eye exam;
- A 20% discount on a complete set of non-covered prescription glasses (frames and lenses), including prescription sunglasses from the same VSP network doctor within 12 months of your last eye exam; and
- A discount off PRK, LASIK and Custom LASIK surgeries available through a laser surgery facility and doctor that has contracted with VSP.

Using a VSP network under the Buy-Up Vision option provides additional benefits. See the chart on the prior pages for more details.

Using a Non-VSP Provider

Dollar for dollar you get the best value from your VSP benefit when you visit a VSP network doctor. If you decide not to see a VSP network doctor, copays still apply and certain services are not covered at all.

You may use any optometrist, ophthalmologist and dispensing optician you choose. If you do not use a VSP network doctor, you must pay the provider in full at the time of your appointment and submit a claim to VSP for reimbursement. See "Applying for Benefits" at the end of this section for more details. VSP reimburses you for up to the amount shown in the chart above.

WHAT'S COVERED

Both the basic and Voluntary Vision plans cover routine eye exams, and materials (where a VSP doctor is used under the Basic Vision program). There are no deductibles for you to meet before benefits are paid. Some services, however, require you to pay a copay before VSP pays benefits. Here are some of the services and eyewear that are covered:

- Eye Exam - A complete initial visual analysis, including an appropriate exam of visual functions and a prescription for corrective eyewear, if necessary;
- Lenses - Clear, standard, glass or plastic; anti-scratch/anti-reflective coating, progressive, polycarbonate;
- Frames - A wide selection of frames is available from which to choose. Your VSP benefit provides guaranteed savings whether you choose a frame that is covered in full or one that exceeds the frame's allowance. Have your doctor help you choose the best frame for you based on your VSP coverage;
- Contacts - Under the Buy-Up Vision program and the in-network services under the Basic Vision program. Lenses necessary to maintain your visual health, which are covered if purchased instead of frames and lenses; and

The "Snapshot" chart at the beginning of this section describes any limits and required copays to receiving your vision care and eyewear.

WHAT'S NOT COVERED

The vision care services and eyewear listed below are not covered by the vision programs. This list is a summary only. If you have questions about a specific vision service or treatment, call VSP.

Vision Coverage

- The cost for services or eyewear above the amount covered by the vision program;
- Replacement of lenses and frames that are lost or broken except at the normal intervals when services are otherwise available;
- Orthoptics (eye muscle exercises) or vision training and any supplemental testing;
- Plano lenses (less than ± .38 diopter power) and any other lenses that can be ordered without a prescription;
- Medical or surgical treatment of the eyes including care for emergency conditions (this service may be covered by your medical option). VSP considers an emergency condition to be a condition, with sudden onset and acute symptoms, that requires immediate medical care, or an unforeseen occurrence calling for immediate, non-medical action.
- Any eye exam required by an employer as a condition of employment; or
- Experimental corrective vision services, treatments and eyewear. For purposes of VSP, services, treatment and eyewear are experimental if the procedure or lens is not used universally or accepted by the vision care profession, as determined by VSP.

You will have to pay the additional costs for any of these excluded services or eyewear.

VSP may, at its discretion, waive any of the limitations or exclusions if, in the opinion of VSP's optometric consultants, it is necessary for the visual welfare of the covered person.

APPLYING FOR BENEFITS

The vision program is easy to use. Depending on whether you go to a VSP network doctor or not, you may not have to file a claim for benefits. If your benefit claim is denied, you may appeal that decision. Read on for more details.

Do You Need to File Claims?

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

If You Use A …	Do You Need to File a Claim?
VSP Network Doctor	No
Non-VSP Provider	Yes

Filing a Claim

When you use a non-VSP provider, you pay for your vision care and eyewear when you receive them. Then, you file a claim for benefits with VSP within 180 days after the date of service for reimbursement of eligible expenses. VSP will reimburse you for expenses you incurred, up to the vision program's benefit levels.

To file a complete claim for benefits, send the following information to VSP:

- An itemized receipt listing the services received;
- Your name, phone number, address and identification number;
- Your Social Security number;
- The patient's name, birth date, phone number, and address;
- Relationship of patient to you (such as "self," "spouse," "child," etc.);
- Our company's name Veolia North America, LLC; and
- Vision provider's name, address and phone number.

Keep a copy of the claim and send the originals to:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

For faster reimbursement, sign on to www.vsp.com, select the "Out-of-Network Reimbursement Form" and follow the instructions to complete the form.

If you file claims after 180 days, your claim will be considered untimely and you may not receive reimbursement for eligible expenses. However,

your claim may not be rejected or reduced if it was not reasonably possible to submit the claim within the 180 day claim period as long as the claim was submitted within one year after the 180 day claim period expires. The only exception for not submitting a claim timely will be for legal incapacity.

If a Claim is Denied

If disagreements arise regarding your claim, every effort is made to resolve them quickly and informally. However, if that is not possible, formal procedures are in place so that you may appeal a decision on your claim. See the "Claims Procedure" section for details on the appeals process.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts

OVERVIEW OF YOUR FLEXIBLE SPENDING ACCOUNTS

The Company offers you a way to pay certain health and dependent care expenses with pre-tax dollars through three types of Flexible Spending Accounts (the "FSAs") - a Health Care FSA, a "Limited Purpose" Health Care FSA and a Dependent Care FSA. As you read about the FSAs, keep the following in mind:

- Each year at annual enrollment, you decide whether or not to use an FSA and how much to contribute during the upcoming year. Because your contributions are not considered taxable income, you may want to consider whether an FSA can help you pay less in taxes in an upcoming year.
- The **Health Care FSA** is designed to help you pay for certain health expenses not eligible for reimbursement through any other source. Note that you are not eligible to participate in the Health Care FSA if you are enrolled in the High Deductible Health Plan option.
- The **Limited Purpose Health Care FSA** is designed to complement your High Deductible Health Plan (HDHP) and Health Savings Account (HSA) coverage by allowing you to pay for certain non-medical expenses (such as dental or vision expenses) that are not eligible for reimbursement through any other source. Note that you can only participate in the Limited Purpose Health Care FSA if you are enrolled in the High Deductible Health Plan option.
- The **Dependent Care FSA** is designed to help you pay for eligible dependent day care expenses you incur while you and your spouse, if any, are at work.
- You make contributions to your FSA through authorized pre-tax salary deductions. These contributions remain in your FSAs until (1) you use them for qualifying expenses, or (2) they are forfeited after the end of the year. If you use your FSA for qualifying expenses, you are reimbursed with tax-free dollars.
- If, at the end of the year, there are funds remaining in an FSA for which you do not submit a timely claim form, you forfeit those amounts as required by Internal Revenue Service ("IRS") regulations.

A SNAPSHOT OF YOUR FLEXIBLE SPENDING ACCOUNTS

We all are looking for ways to save money and the FSAs can be one way to achieve that goal. By using pre-tax dollars to pay certain eligible health and dependent care expenses, you may save some taxes each year. Here is a snapshot of the Health and Dependent Care FSAs:

	Health Care FSA	Limited Purpose Health Care FSA	Dependent Care FSA
Eligible Expenses	Generally, medical, dental, vision and hearing expenses not eligible for reimbursement from any other source and otherwise tax deductible	Generally, dental and vision expenses not eligible for reimbursement from any other source and otherwise tax deductible	Eligible dependent day care expenses you incur while you and your spouse, if any, are at work
Qualified Dependents	Your eligible tax dependents under the Plan (whether or not they are covered under the Company health care programs)	Your eligible tax dependents under the Plan (whether or not they are covered under the Company health care programs)	▪ A child under age 13, ▪ Any disabled dependent that you claim as a dependent on your tax return
Minimum Annual Contribution	There is no minimum contribution level	There is no minimum contribution level	There is no minimum contribution level
Maximum	$2,500	$2,500	$5,000 ($2,500 if married, but

FLEXIBLE SPENDING ACCOUNTS

	Health Care FSA	Limited Purpose Health Care FSA	Dependent Care FSA
Annual Contribution*			file federal income tax return as a single individual)

*Check your enrollment materials for the maximum annual contribution for any given Plan year.

HOW YOUR FLEXIBLE SPENDING ACCOUNTS WORK

You may choose to participate in *either* the Limited Purpose Health Care FSA or the general Health Care FSA, but not both. You may also enroll in the Dependent Care FSA, regardless of which Health Care FSA you participate in, or whether you participate in a Health Care FSA at all. If you decide to participate in an FSA, the Plan Administrator will establish one or two accounts, as applicable, in your name.

Any reference in this section to the Health Care FSA will include both the general purpose Health Care FSA and the Limited Purpose Health Care FSA, except where otherwise indicated.

While the Health and Dependent Care FSAs generally work in the same manner, they are two separate accounts that are subject to some different rules and restrictions. In addition, amounts credited to your Health Care FSA may not be used to reimburse you for your dependent day care expenses, and amounts credited to your Dependent Care FSA may not be used to reimburse you for your health care expenses.

What You Need to Do

To make the FSAs work for you, follow these steps:

- Estimate your expenses

  When you initially enroll, and at each annual enrollment that you decide to participate in the FSAs, you determine in advance how much you expect to spend on health care expenses, and separately on dependent care expenses, for the upcoming year. Because the FSAs offer a tax advantage under IRS rules by letting you pay for eligible expenses on a pre-tax basis, you may not defer amounts in the FSA for use in later years. As a result, you forfeit any unused amounts left in your FSA at the end of the year under the IRS's "use-it-or-lose-it" rule. Therefore, it is important to estimate these expenses carefully.

- Determine how much to contribute

  After estimating your expenses and deciding whether to enroll in the Health Care FSA and/or the Dependent Care FSA, you then decide how much to contribute to each of your FSAs for the upcoming year. Your annual election will be deducted on a pre-tax, prorated basis per paycheck and credited to the appropriate FSA.

  In general, you cannot change the amount of your contributions during the year unless you experience an event that affects your participation and permits you to make a mid-year election change. See "Changing Coverage During the Year" in the "Participation" section of this handbook for more details on events that might qualify for a change in your election.

- Incur expenses

  The FSAs reimburse you for eligible expenses you or your dependents incur during the Plan year (January 1 through December 31). Alternatively, if you start participating in the FSAs because you are a newly eligible employee or as a result of a mid-year event, the FSAs reimburse you for eligible expenses incurred after the effective date of your participation and before December 31. Any expense incurred before your enrollment or after December 31 does not qualify for reimbursement from contributions made to the FSAs during your participation periods.

- Submit claims

  When you receive a bill for expenses that are reimbursable from your FSAs, you can get reimbursement in two ways. First, you can use your FSA debit card at participating merchants. The FSA debit card is convenient because you don't have to have cash on hand and your expenses will be automatically

deducted from your FSA. When you use your debit card, make sure you keep a record of your expense. You may be required to show proof that the expense is eligible. See "FSA Debit Card Reimbursements" below for more information.

Second, you can pay your service provider directly. Then, you would submit a claim form along with the appropriate supporting documentation at www.HealthHub.com.

Filing a Claim for Reimbursement

- Go to www.HealthHub.com
- Click on "File a Claim"
- Enter your claim information
- To add additional claims, select "Add Another Claim"
- Click "Next"
- Select "Fax" or "Upload"
- To fax, click on "Create Coversheet", then print, sign and fax the form and receipts to (866) 932-2567
- To "Upload", use the "Browse" button to select the receipts saved to your computer.
- Check the "Signature Box" at the bottom of the page to sign your claim
- Click "Submit"

Please see "Applying for Reimbursement" at the end of this FSA section for information about what constitutes "supporting documentation." Under this option for reimbursement, payment will be made directly to you and not to any service providers.

- Receive Reimbursement

You are reimbursed for the eligible expense with your pre-tax dollars. This means these reimbursements are not taxable to you. The Health and Dependent Care FSAs impose different rules on when and how claims are paid:

✓ For the Health Care FSA, you are reimbursed for your eligible expenses as you submit claims for such expenses up to the annual amount you elected to contribute, regardless of the actual balance in your Health Care FSA when the claim is received. You will continue to be reimbursed for eligible expenses until your total reimbursements equal the annual amount you elected to contribute to your Health Care FSA.

✓ For the Dependent Care FSA, as you submit claims for eligible expenses, you will be reimbursed for all proper claims, up to the actual amount that is credited to your Dependent Care FSA when the claim is received. If the balance in your Dependent Care FSA is less than the amount of a claim, the claim will be held and reimbursed after additional contributions sufficient to cover the claim have been credited to your Dependent Care FSA.

If You Terminate Employment

Health Care and Limited Purpose Health Care FSAs

Only the expenses incurred through the date on which you cease to be an active employee participating in the Health Care or Limited Purpose Health Care FSA are eligible for reimbursement, unless you continue your participation through COBRA. (See "Health Care Coverage Continuation Rights" in the "Participation" section of this handbook for more details.) You must request reimbursement for such expenses within 90 days from termination, otherwise your remaining account balance will be forfeited.

Dependent Care FSA

You may seek reimbursement for eligible dependent care expenses you incur prior to your termination date, within 90 days of termination.

Please be aware, you will be required to certify that the dependent care expenses were incurred in order for you and, if married, your spouse, to work or to seek employment. If you or your spouse is not working or seeking employment, you will not be able to seek reimbursement for dependent care expenses incurred during that time.

You may not continue your Dependent Care FSA coverage through COBRA following termination of

employment. You must request reimbursement for any eligible dependent care expenses within 90 days of your termination of employment, otherwise your remaining account balance will be forfeited.

"Use-It-or-Lose-It" Rules

As explained above, you will decide how much to contribute to your FSAs. Because you make this decision when you enroll in the FSAs - before you have incurred your expenses for the year - it is possible that you may overestimate your expenses and contribute more than you need to cover your health care and/or dependent care expenses.

However, the tax laws require that all amounts that you contribute to your FSA during the year be used to reimburse eligible expenses that you incur during the same year. If you overestimate your expenses, the tax laws require that any unused pre-tax contributions be forfeited.

You have until March 31 of the next year to submit claims for reimbursement from your FSAs for expenses incurred between the previous January 1 and December 31 (or shorter participation period, if applicable). This extended filing period allows you time to submit any eligible expense you incur shortly before the end of the year. Once this deadline passes, you will forfeit any balance remaining in your FSA after all proper claims have been submitted and paid.

You may not use excess amounts left in your Health Care FSA to pay your dependent care expenses, and vice versa, even if you will otherwise forfeit those amounts.

That is why you must carefully estimate your health and dependent day care expenses when you elect to participate in an FSA. If you budget for emergencies or rare occurrences and they do not occur, you will be likely to end up losing the money.

Apply good judgment in determining how much to put in your FSAs and have a contingency plan to use up any balance remaining in your FSAs at the end of the calendar year.

A Word About Taxes

FSA contributions reduce your taxable income – meaning you pay less in taxes. Your FSA 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. Please see the discussion "Pre-Tax vs. After-Tax" under "Cost of Coverage" in the "Participation" section of this handbook for a general discussion about the impact of reducing your taxable income by pre-tax contributions.

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 care expenses.

Health Care FSA vs. the Income Tax Deduction

Under current tax law, expenses reimbursed through your Health Care FSA are normally deductible on your federal income tax return if they exceed 10% of your adjusted gross income. When you use your FSA 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 FSA, decide whether you want to take the deduction on your income tax return, or seek reimbursement for the expenses through the Health Care FSA. Generally, if you do not itemize deductions, or if your health care expenses are less than 10% of your adjusted gross income, it may be better to use the Health Care FSA. Consult a professional adviser familiar with your personal situation for advice.

Dependent Care FSA vs. the Income Tax Credit

The Dependent Care FSA is not for everyone. In general, if your family's total adjusted gross income for federal income tax purposes is:

- More than $43,000, the Dependent Care FSA may offer greater advantages
- Less than $43,000, the tax deduction 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 anywhere from 20% to 35% of your annual dependent 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 cannot use the Dependent Care FSA 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 such an account. *For example, if you have a single eligible dependent receiving care, and you receive $3,000 in reimbursement from your Dependent Care FSA, you are not eligible for the tax credit because your $3,000 reimbursement is greater than the $1,050 (35% of $3,000) IRS allowable tax credit.* However, you may be able to receive a partial dependent tax credit for expenses that are eligible for the tax credit and exceed the maximum amount allowed for reimbursement under the Dependent Care FSA.

There are some exceptions to this rule. The approach that offers you the better financial advantage will depend on your income and expenses. Your local IRS office can provide you with information that you need to make a decision. Finally, you may want to get advice from your professional tax advisor to help you determine which method is better for you.

Comparison Snapshot:

Dependent Care FSA	vs.	Income Tax Deduction
Immediate savings using pre-tax dollars; no taxes paid up to $5,000 of eligible dependent care expenses for one or more eligible dependents		Deferred savings until you file taxes; tax deduction 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 FSA 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 savings that may result from your participation in the FSAs depend 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 FSAs or to take a tax deduction.

The Company cannot offer you tax advice or advise you on FSA-related decisions. This is 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 FSA

Some health-related expenses that you incur for yourself and your family may not be covered by insurance. *For example, you may be responsible for insurance deductibles and copayments, as well as any expenses in excess of "usual, customary and reasonable charge" limits. In addition, certain medical procedures or treatments may be excluded from insurance coverage entirely.* The Health Care FSA offers you an opportunity to pay for qualified medical expenses with pre-tax salary contributions that you allocate to this account. You may elect to make pre-tax salary contributions up to $2,500 to this account each year, unless your annual enrollment materials provide otherwise. Your Health Care FSA may be used to pay your health care expenses, provided that they are not reimbursable from any other source and, if they eligible for a tax deduction under IRS guidelines, you do not take the tax deduction.

Eligible Dependents

You can use the Health Care FSA to reimburse your eligible dependents' health-related charges. This includes any of your dependents eligible under the Plan, even if your dependents are not covered under the medical program.

However, note that you may only submit expenses for your domestic partner or the children of your domestic partner if those individuals qualify as your Section 152 dependent for tax purposes. See "Domestic Partners: Tax Implications and Other Information" in the "Participant" section of this handbook for more information.

Reimbursable and Non-Reimbursable Expenses

The general purpose Health Care FSA reimburses you for many, but not all, health care expenses that are tax deductible. In general, you can receive reimbursement for expenses incurred for medical care, which includes amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease. But, expenses incurred to merely benefit your general health or for personal reasons (such as, cosmetic surgery, other than to correct or cure a deformity or correct a congenital abnormality) are not considered expenses for medical care.

Remember though, expenses reimbursed by your Health Care FSA may not be claimed as a deduction on your income tax return (if they would otherwise be allowed). The following chart identifies just some examples of eligible and ineligible expenses. Other expenses not listed below may or may not be eligible for reimbursement. To learn more, contact PayFlex at 1.800.284.4885, or visit www.HealthHub.com.

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Reimbursable Expenses	Non-Reimbursable Expenses
▪ Insurance deductibles and copays for office visits and prescriptions ▪ Charges that exceed usual, customary and reasonable limits ▪ Acupuncture if treating a medical condition	▪ 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
▪ All dental expenses if you elect no coverage under the dental program. It may also be used to pay for dental services that are not covered or that have dollar limits, such as orthodontia services ▪ Hearing care expenses, including those for examinations and hearing aids, if not covered under the medical program or other source ▪ Vision care expenses such as examinations, treatments, eyeglasses and contact lens expenses and laser eye surgery 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, prescribed by your doctor ▪ Expenses for medically necessary treatments and procedures that are not covered by insurance ▪ Prescription drugs ▪ Insulin	▪ 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 ▪ Nutritional supplements, vitamins, herbal supplements, or "natural medicines," which are merely beneficial to general health ▪ Sales tax on any qualified expense ▪ Weight loss programs or medications to promote general health ▪ Premiums for medical, dental or vision plans ▪ Over-the-counter medicines and drugs available without a prescription purchased to alleviate or treat physical injury or illness (such as antacid medicine, allergy medicine, pain reliever and cold medicines)

Flexible Spending Accounts

THE LIMITED PURPOSE HEALTH CARE FSA

If you enroll in the HDHP/HSA medical option, you cannot elect to participate in the general purpose Health Care FSA. You are still eligible to contribute to the Limited Purpose FSA to pay for certain non-covered out-of-pocket dental and vision care expenses though. You cannot use this account to pay for general health expenses or over-the-counter medications. The advantage of the Limited Purpose Health Care FSA is that you can pay for your dental and vision expenses while preserving your HSA funds for other purposes. The HSA is not subject to the "use-it-or-lose-it" rule, so you can carry forward these funds indefinitely (even if you leave the Company). For more information on the differences between the Health Care FSA and the HSA, see the "Health Savings Account" section, below.

THE DEPENDENT CARE FSA

You can use the Dependent Care FSA to pay for some or all of the expenses you incur for the care of a child or disabled dependent while you work. 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, if any, 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.
- 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 and comply with all federal, state, and local regulations governing day care centers.
- Your care provider is anyone other than a person whom you claim as a dependent on your federal income tax return (a relative 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.

If You Are Married

Under federal law, if you participate in the Dependent Care FSA and your spouse participates in a similar account through his or her own employer, your combined contributions to both accounts 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, your Dependent Care FSA contributions may not exceed the annual income of the lower-paid spouse.

In general, you may not participate in the Dependent Care FSA 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 he or she 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 to comply with the federal limits.

Eligible Dependents

An eligible dependent is a child younger than age 13 whom you claim as a dependent on your 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;
- Lives with you for at least half of the year; and
- 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 he or she meets all of the above requirements.

Flexible Spending Accounts

Reimbursable and Non-Reimbursable Expenses

The Dependent Care FSA reimburses you for dependent care expenses that are tax deductible so that you and your spouse, if any, may work or attend school full time. Remember though, expenses reimbursed by your Dependent Care FSA may not be claimed as a deduction on your income tax return. It is important to contribute money only for dependent 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 chart identifies just some examples of eligible and ineligible expenses. Other expenses not listed below may or may not be eligible for reimbursement. To learn more, contact PayFlex at 1.800.284.4885, or visit www.HealthHub.com.

Reimbursable Expenses	Non-Reimbursable Expenses
▪ Dependent care provided in your home, including care provided by a babysitter or housekeeper. The provider may be a relative (provided he or she is not your child under age 19, your spouse, or any other person whom you claim as a dependent) ▪ 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 ▪ Household services, such as housekeeping or maid services, provided they are necessary to run your home for the well-being 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	▪ Care provided in 24-hour nursing care facilities ▪ Expenses you claim as an after-tax dependent care tax credit on your federal income tax return, or expenses paid by any similar reimbursement plan ▪ Expenses to attend kindergarten or beyond ▪ 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 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 care cost

APPLYING FOR REIMBURSEMENT

Reimbursement from an FSA is available only after the service for which you are seeking reimbursement is performed and you receive reimbursement from all other sources. As described above, you may request reimbursement for eligible health or dependent care expenses by using your FSA debit card or by submitting a reimbursement request at www.HealthHub.com.

Filing Deadline

You may file claims at any time after you incur the expense. You have until March 31 of the following year to submit claims for expenses incurred between January 1 and December 31 of the previous year. (If you terminate employment, you must file for reimbursement within 90 days of your termination.) Remember, IRS regulations require that you forfeit any money that remains in your FSAs after December 31.

FLEXIBLE SPENDING ACCOUNTS

Health Care Reimbursements

Expenses eligible for reimbursement from other sources must be submitted to that source first. After a payment determination is made, you can submit the unreimbursed expense for reimbursement from your Health Care FSA. Alternatively, you can use your FSA debit card where available, as described below.

The full annual amount you elect to contribute to your FSA (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 FSA.

Supporting Documentation

Along with the reimbursement form, submit the appropriate supporting documentation, such as:

- The explanation of benefits (EOB) from the insurance company
- An itemized bill for services not covered by insurance, including the name of the service provider, cost of the service, and description of the services rendered
- Receipts for any medications and copays

FSA Debit Card Reimbursements

You have the opportunity to pay directly for qualified medical expenses through the use of a FSA debit card. Here is how the FSA debit card feature works

When you enroll in the Health Care FSA each year, you must certify that the FSA debit card will only be used for qualified medical expenses, as defined above (or, in the case of the Limited Purpose Health Care FSA, dental or vision expenses). You must also certify that you will not pay any expense with the FSA debit card that has been reimbursed and that you will not seek reimbursement for the expense under any other plan covering health benefits. The certification will be printed on your FSA debit card, and by using the card, you will reaffirm the certification each time you use the FSA debit card.

When you use the FSA debit card at the point-of-sale, the merchant or provider of service is paid the full amount of the qualified medical expense (assuming your account balance is sufficient), and your maximum available coverage remaining is reduced by that amount. Your use of the debit card is limited to the maximum dollar amount of coverage available in your Health Care FSA.

Your FSA debit card will only work at merchants and providers of service authorized by PayFlex, so the use of the card at other merchants or service providers will be rejected. The Plan limits the FSA debit card's use to specified merchant codes relating to covered health care. Thus, the debit card's use is limited to physicians, pharmacies, dentists, vision care offices, hospitals and other medical care providers of service.

Supporting Documentation

You must retain sufficient documentation for any expense paid with the debit card, including invoices and receipts where appropriate. All charges to the FSA debit card are treated as conditional pending confirmation of the eligibility of the charge through your documentation. When you use your FSA debit card, PayFlex may require you to submit an invoice or receipt from the merchant or provider of service.

Substantiation may not be required when:

- The dollar amount of the transaction at a health care provider exactly equals the dollar amount of the co-payment under the benefit plan for that service;
- The expense is a recurring expense that exactly matches a previously approved qualified medical expense at this provider for the same time period; or
- PayFlex receives verification that the expense is a qualified medical expense by the provider of service, merchant or independent third party (e.g., pharmacy benefit manager).

Keep your FSA Debit Card Active

On HealthHub.com, you can view your FSA debit card status and outstanding card transactions, and you can provide any required documentation.

Here's how:

- Log on to HealthHub.com to confirm your card is active and to determine whether you have any outstanding transactions requiring documentation.
- If you have an outstanding transaction, select "Fax My Receipts" or "Upload My Receipts".
- Once PayFlex has received your documentation, your transaction will be removed from the outstanding transactions list (allow 48 hours for processing).

Repayment for Improper Expenses

If PayFlex finds that any claims have been paid that are not for qualified medical expenses, you are required to refund any amount so identified to the Plan. If you fail to promptly refund the overpayment, the Plan reserves the right to use whatever means possible to offset the improperly reimbursed expenses. In addition, the Plan reserves the right to suspend your use of the FSA debit card and/or credit the overpayment against other qualified medical expenses that you may submit until the overpayment refund is satisfied.

Your FSA debit card will automatically be cancelled if your employment terminates or if your participation in the plan otherwise terminates.

Dependent Care Reimbursements

For Dependent Care FSA claims, only your current account balance is available to reimburse claims. If the dependent care services exceed your account balance, you receive a partial reimbursement. You receive the unreimbursed portion of the claim as you make additional contributions to your Dependent Care FSA.

Supporting Documentation

When you seek reimbursement, please submit:

- Your provider's bill or itemized receipt,
- Your dependent care provider's name, address, and Social Security or federal tax identification number, and
- The Payflex Reimbursement Accounts Claim Form, which includes a certification that the expense was incurred in order for you and, if married, your spouse to work or seek work.

If a Claim is Denied

If disagreements arise regarding your claim, every effort is made to resolve them quickly and informally. However, if that is not possible, formal procedures are in place so that you may appeal a decision. See "Claims Procedures" in the "Participation" section of this handbook for details.

DISTRIBUTIONS DURING MILITARY DUTY

While money contributed to your FSA may generally only be distributed for qualified medical expenses, you might be able to take a distribution of your remaining balance if you are called to active military duty for more than 180 days. Please contact the Plan Administrator for more information.

HEALTH SAVINGS ACCOUNT

Health Savings Account

If you are a participant in the High Deductible Health Plan (HDHP) and otherwise are an Eligible Employee, you may open an individual Health Savings Account (HSA). An HSA allows you to save on a pre-tax basis for future medical expenses.

Unlike the HDHP, your HSA is not an employee welfare benefit plan, is not subject to the Employee Retirement Income Security Act of 1974 (ERISA) and is not required to be summarized in a Summary Plan Description (SPD). Nevertheless, some of the important features of the HSA option are described here.

Legal Responsibility

It is your legal responsibility (and not the Company's) to make sure that any contributions to your HSA (including the Company's contributions) do not exceed the IRS Maximum Allowable Amount for your coverage level. Also note that special rules apply if both you and your Spouse are eligible to contribute to HSAs.

Questions?

If you have questions about your HSA, you can get additional information at www.healthhub.com or contact the Claims Administrator PayFlex at 1-800-284-4885.

HOW YOUR HSA WORKS

Your HSA is an individual custodial account that you establish directly with a bank or other financial institution. You may use the balance in your HSA for reimbursement of qualified medical expenses (as set forth in Code Section 223). Your contributions to your HSA may be made with pre-tax funds and your qualifying withdrawals will be tax-free. Because your contributions are pre-tax, you may save federal income taxes, state income taxes and FICA (Social Security and Medicare) taxes. Check out "Pre-Tax vs. After-Tax" in the Participation section of this SPD for more information about the tax implications of making pre-tax contributions.

If you do not want to make HSA contributions through pre-tax payroll deductions, you can make tax-deductible lump sum contributions to your HSA at any time up to the IRS Maximum Allowable Amount.

WHO IS ELIGIBLE

You are eligible to open and contribute to an HSA under Code Section 223 for any month, if on the first day of such month you:

- Have elected coverage under the HDHP;
- Are not enrolled in and/or covered by any health plan that is not a High-Deductible Health Plan, unless it is a type of permitted limited coverage, such as a Limited-Purpose Health Care FSA;
- Cannot be claimed by another taxpayer (except your Spouse) as a dependent on his or her individual income tax return; and
- Are not eligible for and enrolled in Medicare.

When You Have Coverage Under Your Spouse's Health Plan

You should be aware that coverage under your Spouse's health plan could make you ineligible to contribute to an HSA. This will be the case if:

- your Spouse enrolls you as a dependent under a health plan that is not a High-Deductible Health Plan; or

- your Spouse contributes to his or her employer's general purpose flexible spending account (FSA).

Refer to IRS Publication 969, "Health Savings Accounts and Other Tax Favored Health Plans" for information about the special rules that affect contributions to your HSA. The publication is available from the IRS by calling 1-800-829-3676. Or, you can download a copy of the publication from the IRS Web site at www.irs.gov.

Medicare

IMPORTANT: Read This If You Are Enrolled in Medicare

You cannot make any HSA contributions if you are eligible for and enrolled in Medicare.

ESTABLISHING YOUR HSA

When you enroll in the HDHP option, an HSA will be established for you. For your convenience, the

Health Savings Account

Company has entered into an agreement with PayFlex to provide HSA administration services. The Company will pay your account set-up and maintenance fees. However, any other banking fees that you might incur (e.g., overdraft fees), and any fees assessed by your HSA bank are your responsibility. Also, you are only eligible to receive a Company contribution to your HSA and make pre-tax contributions to your HSA directly from your paycheck if you set up your account with PayFlex.

It is important that you activate your HSA with a financial institution as soon as possible after you enroll in the HDHP option. You will receive a communication from PayFlex as well as from the Company when your account has been established and is ready to be activated. You will have the opportunity to complete the account affirmation process to set up your HSA online at www.healthhub.com. Until your HSA is activated, the Company cannot make any contributions to your account and you cannot use any ATM card, checks or online access to your account.

CONTRIBUTIONS TO YOUR HSA

When you enroll in the HSA Gold and you activate your HSA with PayFlex, the Company will make contributions to your account. You can also make tax-free contributions to your HSA via payroll deductions, up to the IRS Maximum Allowable Amount. If you open your HSA at another bank or financial institution without going through PayFlex, you may still make contributions to your HSA on a tax-deductible basis.

Amount of Contributions

Federal tax law limits the amount that you and/or anyone else, including the Company, can contribute to your HSA on a tax-favored basis each year. The annual HSA contributions (your contributions plus the Company's contributions) cannot exceed the IRS Maximum Allowable Amount, described in the following table:

2014 HSA Annual Maximum Contributions (HSA Gold only)	Employee	Employee + Family
Company	$750	$1,500
Employee (Annual Maximum)	$2,550	$5,050
Catch-up contribution	$1,000	$1,000
IRS Maximum Allowable Amount	$3,300 ($4,300 with catch-up)	$6,550 ($7,550 with catch-up)

If you enroll in the HSA Gold option, the Company will make contributions to your HSA on a prorated basis depending on your eligibility date. See "Timing of Contributions" for additional information.

Catch Up Contributions

In addition to making contributions up to the IRS Maximum Allowable Amounts stated above, if you are age 55 or older, you may also elect to make an annual catch-up contribution to your HSA ($1,000 each year).

Timing of Contributions

HSA contribution maximum amounts are prorated per pay period for the number of months in the calendar year in which you are eligible to contribute to an HSA.

Your per-pay-period contribution election will be made to your HSA from your payroll at the rate of 1/52th each weekly pay period (or 1/26th each bi-weekly payroll, as the case may be).

The Company contributions are made on a prorated, per-pay-period basis. If you are a new hire and enroll in the HSA Gold HDHP plan and establish an HSA for the first time, the Company will make a contribution once you have activated your account with PayFlex. For mid-year hires, the Company will make a prorated, per-pay-period contribution based on your date of hire.

Health Savings Account

Contributions Are Vested

Any contributions that you or the Company make to your HSA are fully vested and are not forfeitable. They remain in your HSA for your use in future years, even when your employment with the Company ends.

ELECTION PROCESS

At the time you elect to enroll in the HDHP, you may also elect to make pre-tax contributions to your HSA. The Company will forward such pre-tax contributions to your HSA within a reasonable time after being withheld from your paycheck. You must activate your HSA through PayFlex to enable the Company to forward your contributions as well as the Company's contribution to your account.

Remember, you are also permitted to establish an HSA outside of PayFlex, but you will not be able to make direct payroll contributions or receive the Company contribution. And you are free at any time to move any or all of your HSA funds from one bank to another authorized bank or other financial institution. You should verify that any contributions you make will be in compliance with the rules regulating HSAs. For additional information on pre-tax contributions to your HSA and IRS Maximum Allowable Amounts, see "Contributions to Your HSA".

Note: You cannot elect to participate in both an HSA and the Health Care Flexible Spending Account (FSA) Plan. If you establish an HSA, you may still participate in the Limited Purpose Health Care FSA, to help pay for certain dental and vision expenses.

Changing Your HSA Pre-Tax Contribution Election

You may elect at any time during the calendar year to start making (as long as you satisfy all of the eligibility requirements), stop making or change the amount of pre-tax contributions to your HSA on a prospective basis for the remainder of the year, in accordance with the Plan's administrative procedures for processing election changes and subject to the statutory limits described in "Contributions to Your HSA".

No changes can be made to other benefit options in the Plan as a result of a change in your pre-tax contribution election to your HSA, unless permitted as a result of a Change in Status event as described in the Participation section of this Handbook. For example, you may stop your HSA contributions at any time during the plan year; however, you cannot change your pre-tax coverage election midyear under the HDHP unless you experience a Change in Status event.

Eligible Employees can elect at any time during the calendar year to start making, stop making, or change the amount of their HSA pre-tax contributions by contacting the Veolia Benefits Center.

WITHDRAWALS FROM YOUR HSA

You must keep track of and request reimbursement on your own from your HSA for the payments you make for qualified medical expenses (whether before or after termination of employment). For more information on what constitutes a "qualified medical expense," see the FSA section. Reimbursements and all other matters relating to maintaining your HSA are not part of the Plan and are to be handled by you and your bank or other financial institution.

The bank or the financial institution with which you establish your HSA will provide you with instructions on how to request reimbursement or withdraw money from your HSA for qualified medical expenses.

If you establish your HSA with PayFlex, you will have access to information about your HSA online at www.payflex.com. While online, you may also view a fee schedule and other account information. If you choose otherwise, the bank will mail instructions and forms for establishing your HSA, a fee schedule, and other account information to your address on record shortly after you enroll in the HDHP. You can also obtain a debit card and/or checkbook to pay for qualified medical expenses.

Reimbursements from your HSA for qualified medical expenses for you or your dependents are not taxable under federal law, even if at the time of the reimbursement you are no longer eligible to contribute to the HSA. However, reimbursements for expenses that are not qualified medical expenses result in taxable income to you, regardless of when the reimbursement is made, and may be subject to an additional 20% penalty. Read "Reimbursable and Non-Reimbursable Expenses" in the Flexible Spending Accounts section for more information about what expenses can and cannot be paid with your HSA.

Health Savings Account

WHO IS MY DEPENDENT?
Please be aware that the definition of "dependent" for purposes of the Health Care FSA is broader than the definition for your HSA. The IRS only permits you to seek reimburse for qualified medical expenses that you, your spouse or your qualified dependent incur. For HSA purposes, your qualified dependent is defined under Internal Revenue Code Section 152 (which generally includes your children up to age 19, or 24 if a full-time student). Please consult with your tax adviser to determine whether your dependent's expenses qualify for reimbursement through your HSA.

WHEN PARTICIPATION ENDS

The Company contributions and your pre-tax payroll contributions to your HSA will be automatically canceled on the last day of the month during the plan year in which:

- Your employment with the Company ends for any reason; or
- Your coverage under the HDHP option ends.

If you otherwise fail to satisfy the HSA eligibility requirements, you should notify the Plan Administrator immediately and your HSA Company contributions and pre-tax payroll contribution election will be canceled. If you make contributions to your HSA when you are no longer eligible, you may incur tax penalties. If the Company makes a contribution to your HSA and you were never eligible, or if the Company makes a contribution that results in you exceeding the IRS Maximum Allowable Amount, the Company reserves the right to recoup the contribution it made on your behalf.

For certain losses of coverage, you or your covered eligible Dependent will have a right to continue coverage under COBRA for the HDHP option. However, the Company will not make contributions to your HSA after you lose coverage under the HDHP option, even if you elect to continue HDHP coverage under COBRA.

OTHER INFORMATION

This section includes additional important information about HSA funding, contribution limits, reporting, claims and tax implications.

Funding

The Company will directly deposit Company contributions and your pre-tax contributions to your HSA established through PayFlex. You are responsible for making contributions to an HSA opened outside of PayFlex.

You are responsible for the investment of funds in your HSA. You may invest your HSA contributions in any way permitted by the bank. You should contact your bank for additional investment information.

Limits on Contributions to Your HSA

Federal tax law limits the amount that you and/or anyone else, including the Company, can contribute to your HSA on a tax-favored basis each year. It is your legal responsibility (and not the Company's) to make sure that any contributions that are made to your HSA (including the Company's contributions) do not exceed the IRS Maximum Allowable Amount for 2013.

The limits are determined each year by federal tax law for each of the coverage levels that are available under the HDHP option. If the contributions made to your HSA exceed the IRS Maximum Allowable Amount, you must remove the excess contributions (and the related investment earnings) from your HSA by April 15th of the following calendar year or they will become taxable income and subject to a 6% penalty tax.

The general rule for 2014 is that all contributions made to your HSA for the full calendar year cannot exceed $3,350 if you elect employee only coverage or $6,550 if you elect employee plus family coverage. This means that, under HDHP:

- If you elect employee only coverage and the Company contributes $750 to your HSA, you can contribute up to $2,550 to your HSA over the course of the calendar year, for a total of $3,350.
- If you elect employee plus family coverage and the Company contributes $1,500 to your HSA, you can contribute up to $5,050 to your HSA over the course of the year, for a total of $6,550.

Health Savings Account

Reporting Issues

The Company will report its contributions to your HSA and your pre-tax HSA contributions on your "W-2 Form." The manager of your individual custodial account also has a reporting requirement to the IRS. You will be provided with a Form 5498-SA reflecting the contributions made to your account during the calendar year and a Form 1099-SA for any distributions that were processed from your account during the calendar year. You are responsible for all other reporting requirements relating to contributions to and distributions from your HSA in connection with filing your individual federal, state and local tax returns.

Claims

Claims for reimbursement from your HSA are administered by your bank or other financial institution in accordance with the HSA custodial agreement between you and your bank or other financial institution.

Tax Implications

You may save federal income taxes, state income taxes and FICA (Social Security and Medicare taxes) by contributing to your HSA. However, different tax rules apply to your HSA benefits than for the benefits offered under other plans described in the Handbook. For example, if you contribute to an HSA when you are not eligible, you may incur tax penalties. Ultimately, it is your responsibility to determine the tax treatment of your HSA benefits.

Refer to the communication materials provided by the bank or other financial institution for more information regarding:

CONTENTS: GENERAL INFORMATION

General Information

PLAN ADMINISTRATION

The Plan Administrator has the sole and complete discretionary authority to determine eligibility for Plan benefits and to construe the terms of the Plan, including the making of factual determinations. The Plan Administrator shall have the discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them. The decisions of the Plan Administrator shall be final and conclusive with respect to all questions relating to the Plan. If a Claims Administrator has the only review authority, the Claims Administrator's decision will be final and conclusive with respect to all questions.

The Plan Administrator may delegate to other persons responsibilities for performing certain duties of the Plan Administrator under the terms of the Plan and may seek such expert advice as the Plan Administrator deems reasonably necessary with respect to the Plan. The Plan Administrator shall be entitled to rely upon the information and advice furnished by such delegates and experts, unless actually knowing such information and advice to be inaccurate or unlawful.

The Plan Administrator may adopt uniform rules for the administration of the Plan from time to time, as it deems necessary or appropriate.

Amendment and Termination

The Company reserves the sole discretionary right to modify, amend or terminate the Plan, in any respect, at any time and from time to time, retroactively or otherwise, by a written instrument adopted by its Board of Directors or its designee. The Company's decision to change or terminate the Plan could result from:

- Changes in federal or state laws governing employee benefits;
- Changes in an insurance contract or policy involving an insurance company;
- Changes in a collective bargaining agreement; or
- Any other reason.

If the Plan is modified, amended or terminated, you will be notified of the effect of such change to your Plan benefits or coverage. However, the modification, amendment or termination may be effective before you are notified. Subject to the terms of any collective bargaining agreement, no consent of any employee or any other person will be necessary for Company to modify, amend or terminate the Plan described in this handbook.

Because contributions for the health care programs stop on the date the Plan ends, the amount of Plan assets available to pay covered claims will not exceed the amount of Plan assets on the termination date.

Representations Contrary to the Plan

No employee, director or officer of the Company has the authority to alter, vary or modify the terms of the Plan except by means of a duly authorized written amendment to the Plan. No verbal or written representations contrary to the terms of the Plan are binding upon the Plan, the Plan Administrator or the Company.

No Assignment

To the extent permitted by law, and except as specified under the terms of the Plan, no benefits will be subject to alienation, sale, transfer, assignment, garnishment, execution or encumbrance of any kind, and any attempt to do so will be void. However, benefits under the Plan may be subject to a Qualified Medical Child Support Order (QMCSO). Coverage under the Plan are non-assignable and non-transferable. You will forfeit coverage under the Plan if you attempt to assign or transfer coverage or attempt to aid any other person in fraudulently obtaining coverage under the Plan.

Recovery of Payments Made by Mistake

You will be required to return to the Company any benefits, or portion thereof, paid under the Plan by a mistake of fact or law.

No Contract of Employment or Service

Your participation in the Plan does not assure you of continued employment with the Company or its affiliates or rights to benefits except as specified under the terms of the Plan. Nothing in the Plan or

in this handbook confers any right of continued employment (or service, as applicable) to any employee or leased employee, as applicable.

Severability

If a court of competent jurisdiction finds, holds or deems any provision of the Plan described in this book to be void, unlawful or unenforceable under any applicable statute or other controlling law, the remainder of the Plan shall continue in full force and effect.

Plan Funding

Benefits offered under the Plan are provided on either a self-insured basis by the Company or are fully insured, as shown in the following chart:

	Self-Insured	Fully Insured
Benefits	Medical Preferred Provider Organization (PPO) Option Medical Exclusive Provider Organization (EPO) Option Medical High Deductible Health Plan (HDHP) Dental Plan (including Delta Dental and CarePlus) Flexible Spending Accounts Short Term Disability	Vision Coverage Life Insurance (Basic, Supplemental and Dependent) Accident Insurance (Basic, Supplemental) Long Term Disability (Core and Buy-Up) Employee Assistance Program Group Legal
Definition	As claims are made, covered benefits are paid from the Company's general assets. However, the Company has administrative services contracts with third-party administrators to decide on and process claims.	An insurance carrier insures the benefits and pays the covered benefits. The Company pays premiums to the insurance carrier for benefit coverage from its own funds as well as employee payroll deductions. In addition, an insurance carrier provides administrative services and makes decisions regarding benefits.

Please see the "Plan Information" chart at the end of this section for more details on which third-party administrators and insurance companies the Company has contracted with to provide services and benefits.

Applicable Law

The Plan described in this handbook shall be governed and construed in accordance with the laws of the State of Illinois to the extent not preempted by the laws of the United States.

Governmental Benefits Exclusion

If services or benefits are reasonably available under any plan or program established by any government or under any plan or program in which any government participates (other than as an employer), benefits under the Plan are not payable for such services or benefits unless payment is legally required. In the case of any person who is not enrolled for all coverage for which he or she has become eligible under any such plan or program, services and benefits available shall nevertheless include all benefits to which he or she would be entitled if he or she were enrolled for such coverage. The term "any government" includes the federal, state, provincial, or local government or any political subdivision thereof of the United States or any country. This provision is subject to any provision or regulation of such plan or program that requires that benefits be utilized before benefits are available thereunder.

Interpretive Authority

If the Plan document does not clearly dictate whether an expense is eligible under the Plan and/or what percentage of the eligible charge is

covered, the Claims Administrator will make a determination and pay benefits accordingly.

Except as provided above, if a question arises as to the interpretation of the terms of the Plan document, the Plan Administrator has discretionary authority to interpret, construe, and apply the terms of the Plan document and to decide any such question, including but not limited to a question as to an employee's eligibility to participate in the Plan.

Statement of ERISA Rights

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

Receive Information About Your Plan and Benefits

- Examine without charge at the Company, 200 East Randolph, Suite 7900, Chicago, Illinois, and major Human Resources offices of the Company, all Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, such as annual financial reports (Form 5500 Series).

- Obtain copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- Receive summaries of the Plan's annual financial reports. These summaries are prepared and distributed to Plan participants each year. The Plan Administrator is required by law to furnish each participant a copy of the summary annual report.

Continue Group Health Plan Coverage

- Under a group health plan, continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the group health plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan regarding the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon 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 or any other person, may discharge you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reasons for the denial. You have the 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 the above 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 because of 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, you may file suit in a state or federal court after you have exhausted the Plan's claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court after you have exhausted the Plan's claims procedures. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are

General Information

discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the Plan Administrator 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 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 Inquires, 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 publications hotline of the Employee Benefits Security Administration.

Plan Sponsor	Veolia North America, LLC 200 East Randolph Street Suite 7900 Chicago, IL 60601 phone number (312) 552-2800 Employer Identification Number: 26-2756568
Plan Administrator	The ERISA Fiduciary Committee of Veolia North America Employee Benefit Plans 200 East Randolph Street Suite 7900 Chicago, IL 60601 phone number (312) 552-2800 Employer Identification Number: 26-2756568
Agent for Legal Service	Veolia North America, LLC 200 East Randolph Street Suite 7900 Chicago, IL 60601 phone number (312) 552-2800 Employer Identification Number: 26-2756568 Service of legal process may also be made on the Plan Administrator.
Plan Name **Plan Number** **Plan Year**	Veolia North America Health and Welfare Benefits Plan 501 January 1 – December 31
Plan Type	The Plan is an employee welfare benefit plan offering group health plan, disability, and life and accident coverage.

General Information

PLAN INFORMATION

Benefit Program	Funding	Claims Administration
Medical Preferred Provider Organization (PPO)	Self-Insured by the Company	Blue Cross Blue Shield of Illinois 800-995-0582 www.bcbsil.com
Medical Exclusive Provider Organization (EPO) Option		
Medical High Deductible Health Plan (HDHP) Option		
Medical Preferred Provider Organization (PPO)	Self-Insured by the Company	UnitedHealth Care 866-747-1020 www.myUHC.com
Medical Exclusive Provider Organization (EPO) Option		
Medical High Deductible Health Plan (HDHP) Option		
Dental	Self-Insured by the Company	Delta Dental of Illinois 1-800-323-1743 www.deltadentalil.com
	Insurance contract with CarePlus	CarePlus 1-800-318-7007 www.careplusdentalplans.com
Vision	Insurance contract with Vision Service Plan (VSP)	Vision Service Plan P.O. Box 997105 Sacramento, CA 95899-7105 1-800-877-7195 www.vsp.com
Flexible Spending Accounts	Self-Insured by the Company	PayFlex 1-800-284-4885 www.HealthHub.com
Health Savings Account	Not applicable	PayFlex 800-284-4885 www.HealthHub.com
COBRA Administrator	Not applicable	PayFlex 800-284-4885 www.HealthHub.com

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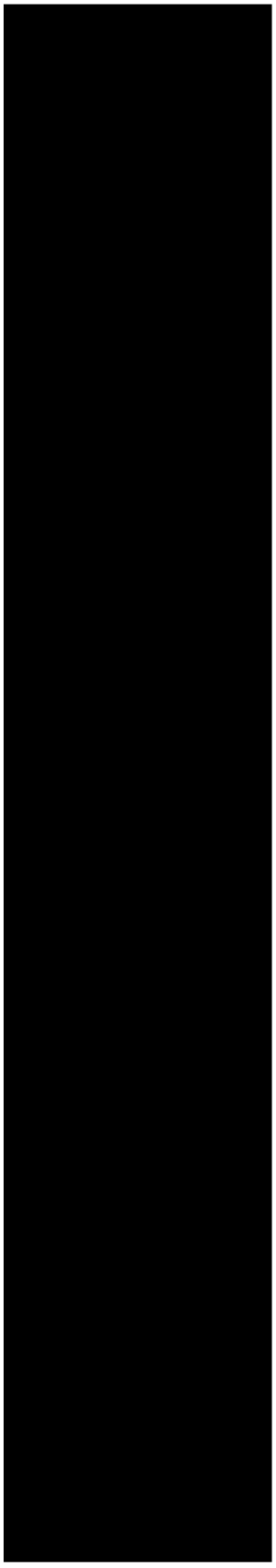
Benefit Program	Funding	Claims Administration
Employee Assistance Program	Insurance Contract with: Magellan Behavioral Health P.O. Box 7777 Philadelphia, PA 19175	Magellan Behavioral Health P.O. Box 7777 Philadelphia, PA 19175 1-800-324-8914 www.magellanhealth.com/member
Short-Term Disability	Self-Insured by the Company	Cigna 888-84-CIGNA (842-4462) www.myCigna.com
Long-Term Disability (Core and Buy-Up)	Insurance contract with: Reliance Standard	Reliance Standard 800-351-7500 www.RelianceStandard.com
Life Insurance (Basic, Supplemental and Dependent)	Insurance contract with: Reliance Standard	Reliance Standard 800-351-7500 www.RelianceStandard.com
Accident Insurance (Basic and Supplemental)	Insurance contract with Reliance Standard	Reliance Standard 800-351-7500 www.RelianceStandard.com
Group Legal	Insurance contract with: Hyatt Legal	Hyatt Legal 800-821-6400 www.LegalPlans.com



Glossary

- ***Annual Deductible***

The amount an employee is required to pay for covered expenses before a health care program begins to pay benefits. Refer to the description of the health care coverage options to determine whether a deductible must first be met.

- ***Annual Enrollment***

Period of time before the first day of a Plan year during which eligible employees may make elections with respect to coverage under one or more benefit programs for themselves and their eligible dependents, which elections shall take effect in the immediately following Plan year. Eligible employees may make enrollment changes during annual enrollment without a change in status. The Plan Administrator establishes the annual enrollment period. See "Annual Enrollment" in the "Participation" section of this handbook for details regarding when elections made during annual enrollment take effect.

- ***Annual Out-of Pocket Maximum***

The maximum amount of expenses (including any deductible) an employee pays in covered health care expenses in a Plan year. Once the annual out-of-pocket maximum is met, covered services are paid at 100% of the negotiated network fee or usual, customary and reasonable charges, as applicable, for the remainder of the Plan year, subject to the lifetime maximum benefit. Certain expenses are not included in determining whether the annual out-of-pocket expenses are met, including copayments, expenses above usual, customary and reasonable charges, penalties incurred for not satisfying preapproval requirements and coinsurance amounts for any mental health or substance abuse treatments.

- ***Basic Life Insurance***

The Company-funded insurance that provides a benefit to an employee's beneficiary (or beneficiaries) in the event of the employee's death. The Company automatically provides a certain level of basic life insurance coverage to eligible employees.

- ***Brand-Name Drug***

The trademark name of a prescription drug.

- ***Calendar Year Maximums***

Limits on the number of days or visits permitted for certain services or on the dollar amount paid for certain services under health care coverage option. Once the limit is met in a Plan year, services incurred in excess of the limit will not be covered.

- ***Certificates of Creditable Coverage***

A certificate issued to a participant or covered dependent after the individual loses medical coverage, which confirms the length and type of coverage the individual had under the Company's medical program. The certificate allows the individual to reduce or eliminate any pre-existing exclusion a new employer's plan or insurance policy imposes.

- ***Claims Administrator***

An insurance company or other party that has contracted with the Company to provide administrative services to a benefit program and is responsible for determining whether a particular claim is covered by such benefit program. In some cases, the Plan Administrator will be the Claims Administrator. See "Claims Procedures" in the "Participation" section of this handbook for details.

- ***COBRA***

Consolidated Omnibus Budget Reconciliation Act of 1985, a federal law that extends group health care coverage to employees and their qualifying dependents who lose group health care coverage as a result of certain qualifying events. COBRA requires employers to offer covered employees 18, 29, or 36 months (for Health Care FSA, through the end of the year under certain circumstances) of continued coverage for a contribution based on the cost of the coverage plus a 2% administration fee (or a 50% administration fee for a qualifying 11-month disability extension).

- ***COBRA Administrator***

The COBRA administrator assists the Company in sending the necessary paperwork to eligible employees to elect COBRA coverage and collects COBRA premiums.

- ***Coinsurance***

The percentage of covered expenses for which an employee is responsible after he meets any applicable deductible or copay requirement.

Glossary

- ***Company***

Veolia North America, LLC

- ***Concurrent Disability***

A new, non-work related disability that occurs while the employee is receiving benefits for another covered disability.

- ***Conversion Rights***

The right to convert group life insurance coverage to an individual life insurance policy without satisfying any evidence of insurance requirements when group life insurance ends. Conversion rights may be limited under certain circumstances. See "Insurance Conversion or Continuation Rights" in the "Participation" section of this handbook for more details.

- ***Coordination of Benefits or COB***

If an employee or covered dependent participates in more than one health care plan, the plans determine which coverage pays first.

- ***Copayment***

A flat dollar amount that you pay directly to your provider for certain covered services at the time you receive services. *For example, a $30 copayment for office visits with primary care physicians.* Copayments or "copays" do not apply toward any out-of-pocket limits. A copay is generally required before services are paid under the EPO option (provided service is received through the EPO network). While copays are generally not required under the PPO option, they may be required for certain services.

- ***Core Long-Term Disability Coverage***

Coverage that provides income protection in the event of a long-term disability.

- ***Coverage Option***

An option available under a health care program and includes, for example, the PPO and EPO. Under a coverage option, such as the PPO, a premium and select level of coverage may be offered.

- ***Covered Dependent***

An eligible dependent whom an eligible employee has enrolled in medical, dental, vision, dependent life and/or voluntary accident coverage.

- ***Deductible***

See "Annual Deductible."

- ***Dependent***

An individual who qualifies as a dependent of an eligible employee for coverage under a benefit program described in this handbook, and includes, the employee's spouse and dependent children. Individuals who are otherwise "dependents" shall not be eligible for coverage under a benefit program if they serve in the military of any country or reside outside of the United States or Canada.

- ***Dependent Care FSA***

A flexible spending account to which an eligible employee can elect to make contributions, on a pre-tax basis, that are later used to help pay for eligible dependent care expenses incurred while the employee and his or her spouse, if any, are at work.

- ***Dual Coverage***

Enrollment as an employee as well as a dependent of an eligible employee. Dual coverage is not permitted.

- ***Eligible Employee***

An employee who satisfies the requirements to be eligible to elect coverage under the programs described in this handbook.

- ***Emergency***

A medical condition manifesting itself by acute symptoms of sufficient severity (including pain) that the absence of immediate medical attention could reasonably be expected to result in death or serious bodily (or psychological) harm to you and/or others.

- ***Emergency Behavioral Health Services and Care***

Screening, examination, and evaluation services that are furnished in order to evaluate and/or stabilize an individual experiencing an emergency

medical condition (including emergency mental health or substance abuse conditions).

- ***Emergency or Emergency Medical Condition***

An emergency medical condition means the unexpected onset of a health condition that could result in jeopardy to one's body or life.

For purposes of the medical option, a sudden, serious and unexpected illness, injury or health problem (including sudden and unexpected severe pain). This includes any illness, injury or health problem an employee reasonably believes could endanger the employee's health if medical care is not received right away. the Claims Administrator or the employee's medical group will make the final decision about whether services were given for an emergency.

- ***Emergency Services***

For purposes of the medical option, services given because of a medical or psychiatric emergency.

- ***Employee Assistance Program***

A Company-funded benefit program offering eligible employees a variety of resources to assist with personal concerns.

- ***EOB***

See Explanation of Benefits.

- ***EPO***

See Exclusive Provider Organization.

- ***ERISA***

The Employee Retirement Income Security Act of 1974, as amended, which establishes certain rights and protections for participants.

- ***Evidence of Insurability***

A statement of the employee's or dependent's medical history which is used to determine whether the employee or dependent is approved for coverage. Evidence of Insurability is provided at the employee's expense, and may be required for long-term disability coverage, supplemental life insurance coverage and/or dependent life insurance coverage.

- ***Exclusive Provider Organization***

A medical program coverage option that provides comprehensive benefits, including preventive care, and typically requires copayments for most services. Individuals enrolled in an EPO must receive all care from a provider associated with the EPO.

- ***Experimental***

For purposes of the medical option, procedures that are mainly limited to laboratory and/or animal research.

- ***Explanation of Benefits***

A printed statement addressed to the employee or provider that itemizes services performed and benefit information related to those services, including how much, if any, of the claim is paid for under the health program.

- ***FMLA***

The Family and Medical Leave Act of 1993.

- ***Formulary***

A comprehensive list of recommended prescription medications that is created, reviewed, and continually updated by a team of physicians and pharmacists. The formulary contains a wide range of brand-name preferred products that are approved by the Food and Drug Administration.

- ***Fraud***

Knowingly making, or causing or permitting to be made, false statements in order for you or another person to obtain services or payment to which you or the other person are not entitled. Fraud includes any act that constitutes fraud under applicable federal or state law.

- ***Fully-Insured Plan***

A plan under which an insurance carrier insures the benefits and pays the covered benefits. The Company pays premiums to the insurance carrier for benefit coverage from its own funds as well as employee payroll deductions. In addition, an insurance carrier provides administrative services and makes decisions regarding benefits.

Glossary

- ***Gainful Occupation***

For purposes of the Long Term Disability program, an occupation, including self-employment, that is or can be expected to provide an employee with an income equal to at least 60% of the employee's indexed monthly earnings within 12 months of his or her return to work.

- ***Generic Drug***

A chemical copy of a brand-name prescription drug.

- ***Health Care FSA***

A flexible spending account to which an eligible employee can elect to make contributions, on a pre-tax basis, that are later used to help pay for eligible health care expenses that the employee and his or her eligible dependents incur.

- ***Health Insurance Portability and Accountability Act***

The Health Insurance Portability and Accountability Act of 1996 requires employers to provide certificates of creditable coverage to minimize pre-existing exclusions imposed by employers under group health plans, and provides employees with special enrollment opportunities for medical coverage.

- ***HIPAA***

See Health Insurance Portability and Accountability Act.

- ***Investigative***

For purposes of the medical option, procedures or medications that have progressed to limited use on humans, but which are not generally accepted as proven and effective within the organized medical community.

- ***Leave of Absence***

A period of Company-approved absence from service that is not treated as a termination of employment in accordance with the Company's employment policies, including an absence under FMLA or to perform military service protected under the Uniformed Services Employment and Reemployment Rights Act of 1994.

- ***Legal Spouse***

The individual to whom an employee is legally married, including by reason of the common law statutes in the state of the Participant's principal residence. A spouse does not include an individual legally separated from the employee under a decree of divorce or separate maintenance nor does it include, for purposes of the Dependent Care FSA, an individual who, although married to the employee, files a separate federal income tax return, maintains a separate residence during the last six months and does not furnish more than one-half of the cost of maintaining the principal residence of the individual for whom expenses are eligible for reimbursement under the Dependent Care FSA.

- ***Lifetime Maximum***

The sum of all benefits the medical program pays for any covered individual during his or her lifetime.

- ***Medically Necessary***

For purposes of the medical options, procedures, services, supplies or equipment that the Claims Administrator decides are:

- Appropriate and necessary for the diagnosis or treatment of the medical condition;
- Provided for the diagnosis or direct care and treatment of the medical condition;
- Within standards of good medical practice within the organized medical community;
- Not primarily for the employee's convenience, or for the convenience of the employee's doctor or another provider; and
- The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
  - ✓ There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, equipment, service or supply are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition

being treated than other possible alternatives; and

- ✓ Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and

- ✓ For hospital stays, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

- ***Mental Illness***

For purposes of the Long Term Disability program, a psychiatric or psychological condition regardless of cause. Mental illness includes but is not limited to depression, manic depression or bipolar illness, anxiety, somatization, substance related disorders and/or adjustment disorder or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment as standardly accepted in the practice of medicine.

- ***Negotiated Network Fee***

The fee for covered services negotiated between the PPO and a network provider.

- ***Network***

A group of U.S. hospitals, physicians, specialists, ancillary providers, etc., that meet specific criteria and that agree to provide services at negotiated rates to participants covered by the PPO and/or the Traditional Group Dental option.

- ***Network Provider***

A provider who has contracted with the medical or dental PPO to provide appropriate medical or dental care at a negotiated network fee. A higher level of benefits is paid when care is received from a network provider.

- ***Newborns' and Mothers' Health Protection Act***

The Newborns' and Mothers' Health Protection Act requires medical plans to provide a minimum hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after a cesarean section unless the attending physician, in consultation with the mother, determines a shorter hospital length of stay is adequate.

- ***Out-of-Pocket Limit***

See Annual Out-of-Pocket Maximum.

- ***Own Occupation***

For purposes of the disability programs, the essential functions you regularly perform that provide your primary source of earned income.

- ***Plan***

The Veolia North America Health and Welfare Benefits Plan.

- ***Plan Administrator***

The ERISA Fiduciary Committee of the Veolia North America Employee Benefit Plans or other entity designated from time to time by the Board of Directors of the Company to supervise the administration of the Plan. The Plan Administrator is the "named fiduciary" of the Plan, within the meaning of ERISA Section 402(a). The Plan Administrator may delegate to other persons responsibilities for performing certain of its duties.

- ***Plan Year***

The calendar year.

- ***Portability Rights***

The right to continue supplemental life insurance coverage by paying premiums directly to the insurance company instead of exercising the conversion rights. If you continue supplemental life insurance coverage, you also have the right to continue basic and voluntary accident coverage by paying premiums directly to the insurance company instead of exercising conversion rights. Evidence of insurability is generally required. See "Insurance Conversion or Continuation Rights" in the "Participation" section of this handbook for more details.

- ***Post-Service Claim***

A medical benefit claim that is not a pre-service claim, urgent care claim or concurrent care claim.

For example, a claim for reimbursement after medical care is received.

- ***PPO***

See Preferred Provider Organization.

- ***Preferred Provider Organization***

A medical program coverage option that pays a higher level of benefits when care is received from a network provider. Services received from a non-network provider may also be covered, but at a lower level of benefit.

- ***Pre-Service Claim***

A medical benefit claim that requires approval before the covered individual can receive coverage (in whole or in part) for the medical care.

- ***QMCSO***

See Qualified Medical Child Support Order.

- ***Qualified Medical Child Support Order***

A medical child support order, approved by the Plan Administrator, that provides for health care coverage and allocation of responsibility for the payment of costs for health care coverage for a child of an employee.

- ***Qualifying Event***

An event that, following a loss of health care coverage, triggers an employer's COBRA obligation.

- ***Self-Insured Program***

A program under which covered benefits covered benefits are paid from the Company's general assets, as claims are made. However, the Company has administrative services contracts with third-party administrators to decide on and process claims.

- ***Short-Term Disability (Short Term Disability) Coverage***

The Company-funded income protection for eligible employees who become disabled under the terms of the Short Term Disability program. The Company automatically provides a certain level of income protection for most eligible employees.

- ***Urgent Care***

Medically necessary care received at an urgent or immediate care center to prevent serious deterioration of a covered individual's health resulting from an unforeseen illness or injury manifesting itself by acute symptoms of sufficient severity, which may include severe pain.

For purposes of the medical option, services an employee receives for a sudden, serious or unexpected illness, injury or condition to keep the employee's health from getting worse. It is not an emergency. Care is needed right away to relieve pain, find out what is wrong, or treat the health problem.

- ***Urgent Care Claim***

A medical benefit claim where applying the non-urgent care time frames (i) could seriously jeopardize the claimant's health or ability to regain maximum function, or (ii) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain without the care or the treatment that is the subject of the claim.

- ***Visually Necessary***

For purposes of the VSP, services and materials medically or visually necessary to restore or maintain a patient's visual acuity and health and for which there is no less expensive professionally acceptable alternative, as determined by VSP.