	High Deductible Health Plan - Silver	High Deductible Health Plan - Gold	PPO	EPO
Maximum Annual Employer Contribution to a Health Savings Account	$0	Employee Only: $750* All Other Coverage Tiers: $1,500*	$0	$0
Employer HSA contributions are prorated based on the date your High Deductible Health Plan - Gold coverage starts and deposited per your payroll schedule, not as a lump sum. If you do not work a full calendar year, you will not receive the maximum annual contribution shown above.				
Annual Deductible (In-Network) • Individual • Family ** Prescription copay/coinsurance does not count toward deductible	$3,000 $6,000	$1,500 $3,000	$750** $1,500**	$500** $1,000**
Annual Deductible (Out-of-Network) • Individual • Family ** Prescription copay/coinsurance does not count toward deductible	$5,400 $10,800	$3,000 $6,000	$1,500** $3,000**	N/A; out-of-network benefits are not provided in this plan
Out-of-Pocket Maximum (In-Network) • Individual • Family (Amount includes medical and prescription copays, coinsurance and deductible)	$6,900 $13,800	$3,000 $6,000	$3,000 $6,000	$2,500 $5,000
Out-of-Pocket Maximum (Out-of-Network) • Individual • Family (Amount includes medical and prescription copays, coinsurance and deductible)	$13,500 $27,000	$6,000 $12,000	$6,000 $12,000	N/A; out-of-network benefits are not provided in this plan
Lifetime Maximum	None/Unlimited	None/Unlimited	None/Unlimited	None/Unlimited
Coinsurance - You Pay • In-Network • Out-of-Network	30% 50%	20% 50%	20% 50%	10% In-Network; Out-of-network benefits are not provided
Preadmission Certification	Required; $300 penalty	Required; $300 penalty	Required; $300 penalty	Required; $300 penalty
Office Visits • Primary Care Physician/Specialist and Virtual Visits (Virtual Visits are in network only)	After deductible, 30% in-network coinsurance 50% out-of-network coinsurance	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance	After deductible, 10% in-network coinsurance; Out-of-Network benefits are not provided

HIGHLIGHTS OF MEDICAL PLAN OFFERINGS

	High Deductible Health Plan - Silver	High Deductible Health Plan - Gold	PPO	EPO
Preventive Care (Annual physicals, well-women care, well-child care, PSA tests, etc.)	**If in-network, covered at 100% with no out-of-pocket cost to employee. If out-of-network, subject to out-of-network deductible and coinsurance, if applicable.**			
Inpatient Hospital	After deductible, 30% in-network coinsurance 50% out-of-network coinsurance	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance	After deductible, 10% in-network coinsurance; Out-of-Network benefits are not provided
Outpatient Surgery	After deductible, 30% in-network coinsurance 50% out-of-network coinsurance	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance	After deductible, 10% in-network coinsurance; Out-of-Network benefits are not provided
Outpatient Hospital/Facility Services (includes such services as radiation therapy, chemotherapy, renal dialysis, electroconvulsive therapy, diagnostic services)	After deductible, 30% in-network coinsurance 50% out-of-network coinsurance	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance	After deductible, 10% in-network coinsurance; Out-of-Network benefits are not provided
Lab and X-Ray • Physician's Office • Hospital or Outpatient Facility	After deductible, 30% in-network coinsurance 50% out-of-network coinsurance	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance	After deductible, 10% in-network coinsurance; Out-of-Network benefits are not provided
Emergency Room • True emergency • Non-Emergency	30% after deductible 50% after out-of-network deductible for Non-Emergency	20% after deductible 50% after out-of-network deductible for Non-Emergency	20% after deductible 50% after out-of-network deductible for Non-Emergency	10% after deductible No coverage for out-of-network if Non-Emergency
Urgent Care	After deductible, 30% in-network coinsurance 50% out-of-network coinsurance	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance	After deductible, 10% in-network coinsurance; Out-of-Network benefits are not provided
Skilled Nursing Facility (100 day max*)** **Home Health Care (120 visit max***)** **Hospice Care**	After deductible, 30% in-network coinsurance 50% out-of-network coinsurance	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance	After deductible, 10% in-network coinsurance; Out-of-Network benefits are not provided

***Maximums are on a calendar year basis and applies to both in-network and out of network coverage**

HIGHLIGHTS OF MEDICAL PLAN OFFERINGS

	High Deductible Health Plan - Silver	High Deductible Health Plan - Gold	PPO	EPO
Therapies • Physical • Occupational • Speech (60 visit per therapy annual maximum)*** • Chiropractic and Osteopathic **(Combined 60 visit annual maximum)***** • Acupuncture **(Combined 20 visit annual maximum)**	After deductible, 30% in-network coinsurance 50% out-of-network coinsurance	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance	After deductible, 10% in-network coinsurance; Out-of-Network benefits are not provided
Maternity Care • Pre/post natal care • Delivery charges (physician only) • In-hospital doctor visit • Inpatient hospital	After deductible, 30% in-network coinsurance 50% out-of-network coinsurance	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance	After deductible, 10% in-network coinsurance; Out-of-Network benefits are not provided
Infertility Coverage • Testing and Diagnosis • Voluntary sterilization • Advanced Reproductive Technology (ART) includes artificial insemination, ovulation induction and IVF treatment.	After deductible, 30% in-network coinsurance 50% out-of-network coinsurance Not Covered	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance Not Covered	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance Not Covered	After deductible, 10% in-network coinsurance; Out-of-network benefits are not provided Not Covered
Mental Health and Substance Abuse • Inpatient • Outpatient	After deductible, 30% in-network coinsurance 50% out-of-network coinsurance	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance	After deductible, 10% in-network coinsurance; Out-of-Network benefits are not provided
Ambulance Services Note: Non-emergency ambulance services for out-of-network providers are subject to out-of-network deductible and co-insurance. True emergencies will be covererd at the in-network deductible and coinsurance.	After deductible, 30% in-network coinsurance 50% out-of-network coinsurance	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance	After deductible, 20% in-network coinsurance 50% out-of-network coinsurance	After deductible, 10% in-network coinsurance; Out-of-Network benefits are not provided

***Maximums are on a calendar year basis and applies to both in-network and out of network coverage**

VEOLIA NORTH AMERICA, LLC
HIGHLIGHTS OF MEDICAL PLAN OFFERINGS

PRESCRIPTION DRUG COVERAGE

When you enroll in any Veolia medical plan, prescription drug coverage through Express Scripts is automatically included. Your prescription drug benefits will vary depending on which medical plan option you choose, the type of medication you are prescribed and whether you get it filled using a participating retail pharmacy or by home delivery.

PRESCRIPTION DRUGS	High Deductible Health Plan Silver	High Deductible Health Plan Gold	PPO	EPO
Retail (30-day supply):	**Employee Pay**	**Employee Pay**	**Employee Pay**	**Employee Pay**
>Generic	30% after deductible+	20% after deductible+	$10 copay	$10 copay
>Brand			25% (min $30/max $75)	25% (min $30/max $75)
>Non-Formulary			35% (min $50/max $110)	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)	100% of the retail cost (after second purchase)
Home Delivery (90-day supply):	**Employee Pay**	**Employee Pay**	**Employee Pay**	**Employee Pay**
>Generic	30% after deductible	20% after deductible	$25 copay	$25 copay
>Brand			25% (min $75/max $150)	25% (min $75/max $150)
>Non-Formulary			35% (min $125/max $225)	35% (min $125/max $225)

+ In the High Deductible Health Plans - Gold and Silver, you will pay full price for prescriptions until you meet your medical deductible.

++ If you take a maintenance medication, such as those used to treat high blood pressure or high cholesterol, you'll pay the entire cost for a maintenance medication at a retail pharmacy after the second purchase if you do not have that prescription filled through home delivery. To avoid higher costs, take advantage of the home delivery pharmacy services from Express Scripts. For more information, contact Express Scripts at 1-888-792-7276 or Express-Scripts.com