American Water Works Summary Plan Description For Union Employees

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In preparing this Summary Plan Description. American Water Works has attempted to avoid complex language and legal terms whenever possible.

This is intended as a summaiy, not a complete description of the plan. In the case of a conflict between this summary and the legal documents comprising the plan, those legal documents will govern.

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Introduction

Introduction

At American Water Works, leadership, vision, and achievement have become a proud tradition. Today, we are poised to build upon this tradition, thanks to the skills, teamwork, and dedication of our valued employees.

Your American Water Works benefits can add up to a significant part of your total compensation, providing you with added security and peace of mind.

In recognition of the efficiency and commitment with which our employees approach each new challenge, American Water Works provides yon with a competitive total compensation package that, in many ways, sets an industry standard. A cornerstone of this package is our employee benefits program. This Summary Plan Description describes the following American Water Works employee benefit plans:

- Your Medical Plans
  - The Managed Choice Plan
  - The HMO Elect Choice Plan
  - The Out-Of-Area Comprehensive Medical Plan
  - The Medical Opt-Out Option
- The Prescription Drug Plan
- The Dental Plan
- Flexible Spending Accounts
  - Health Care Spending Account
  - Dependent Care Spending Account
- Short-Term Disability
- Life Insurance
  - Basic and Optional Group Term Life Insurance
  - Voluntary Life Insurance
  - Spouse and Dependent Life Insurance
  - Accidental Death & Dismemberment Insurance
  - Travel Accident Insurance

The benefits described are provided by American Water Works Company, Inc., referred to as American Water Works throughout this Summary Plan Description.

Please read this Summary Plan Description carefully and refer to it whenever you have questions about American Water Works benefits program or the specific coverages that apply to you. If you have questions about these plans, please contact your Human Resources representative.

The Company expects to continue this Plan, but reserves the right to amend it, or terminate it, at any time, in whole or in part. The authority to make any such changes to the Plan generally rests with the Board of Directors of American Water Works, although the Plan Administrator may also change the Plan as required by law or in a manner which will not result in a material cost. Some of the employees who participate in this Plan do so under the terms of collective bargaining agreements. The Company takes its obligations under those agreements very seriously and will, as required either by the Company's contractual agreements or by law, negotiate changes to the Plan affecting union members with those unions whose members participate in the Plan.

If a question should ever arise concerning the nature and extent of benefits under any aspect of these plans, the actual legal plan documents – and not this Summary Plan Description – will govern

Eligibility

Eligibility

If you are a regular full-time American Water Works union employee (working more than 35 hours a week) covered under the national benefits Memorandum of Agreement, you and your family are eligible to participate in the benefits described in this Summary Plan Description. Your eligibility date is the first day of the month, following completion of one full month of continuous service with the Company.

Participation in the plans you select begins on the first day of the month, following completion of one full month of continuous service with the Company, provided you are then actively working or would have been able to work had you been scheduled to work that day. If you are on a layoff on disability, or on leave of absence on your eligibility date, coverage will begin on the day you return to active work

Your eligible dependents include:

- Your wife or husband.
- Your unmarried children from birth to age 19 who are:
  - Fully dependent on you for support
  - Not employed full-time and
  - Not in the military service

  The word "children" includes adopted children, foster children, grandchildren, and stepchildren who meet all of the above criteria, live with you in a parent-child relationship, and must be claimed as dependents for federal income tax purposes.

  The phrase "live with you in a parent-child relationship" means that the child resides in your home on a permanent basis as the place of his or her legal residence – even though the child may be away from your home during certain *periods* of the year (e.g., to attend school).

  Adopted children are eligible to participate in an **American** Water Works medical plan on the date they are placed for adoption **A** child is considered 'placed" when you assume and intend to retain a legal obligation for the child's support, in anticipation of adopting the child – regardless of where the child resides.
- Your unmarried children ages 19 to 23, while:
  - Fully dependent on you for support
  - Full-time students
  - Not employed full-time and
  - Not in the military service

Dependents cannot participate unless you, the employee, also participate. An individual is not eligible both as an employee and as a dependent, nor as a dependent of more than one employee.

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An Overview of Your Options

Eligible employees and their dependents may participate in the Managed Choice or HMO Elect Choice Plan. The Out-of-Area Comprehensive Medical Plan is available only to employees who live in an area where a managed care network is not available. You also have the ability to opt out of medical coverage.

The Managed Choice Plan

The Managed Choice Plan is a point of service plan that emphasizes both preventive care and protection against the cost of illness and serious injury.

The Managed Choice Plan is a managed care plan. The Plan is self-insured by American Water Works. Aetna provides certain administrative services under the Plan. The Managed Choice Plan emphasizes preventive care, and protects you against the cost of illness and serious injury while providing you with access to higher levels of benefits.

The HMO Elect Choice is a plan that emphasizes both preventive care and protection against the cost of illness serious injury with in-network benefits only.

For you to receive the advantages of the Managed Choice Plan, your care must be provided or coordinated by a Primary Care Physician (PCP). PCPs include general practitioners, family practitioners, internists, and pediatricians from your own community. If you live in a designated area and enroll in the Plan, you and each covered member of your family select a PCP. To learn which physicians are in the network, call Aetna at (800) 292-4366 or log on to the Aetna website at www.aetna.com and click on DocFind. For a detailed description of the Plan, please see pages 19-58.

The HMO Elect Choice Plan

An HMO is a managed care plan that is self-insured by American Water Works. It has a network of doctors, clinics, and hospitals that

provides all types of health care services, including office visits, hospital stays, and surgery. Unlike the Managed Choice Plan, you do not receive benefits for services received outside of the HMO network. If you choose an HMO for your medical coverage, you must choose a primary care physician (PCP) from the insurance company's network to coordinate your care. This means that if you need to see a specialist, your PCP must refer you to an appropriate provider. With this plan, there are never any claim forms to file. To learn which physicians are in the network, call Aetna at (800) 292-4366 or log on to the Aetna website at www.aetna.com and click on DocFind. For a detailed description of the Plan, please see pages 59-87.

The Out-Of-Area Comprehensive Medical Plan

The Out-of-Area Comprehensive Medical Plan option is a traditional plan designed to protect you against the cost of illness and serious injury.

The Out-of-Area Comprehensive Plan is a self-insured plan by American Water Works. The Plan covers the expenses you or a family member may incur as the result of a serious illness or injury, as well as many routine medical expenses. You may use any licensed doctor or hospital you choose. For a detailed description of the Plan, please see pages 89-107.

Listings of Network Providers

Listings of network providers are available to participants and beneficiaries as a separate document from www.aetna.com, free of charge.

The Medical Opt-Out Option

The Medical Opt-Out Option allows you to opt out of the medical plan and receive a $100 payment per month.

The Medical Opt-Out Option gives you the opportunity not to elect medical coverage. If you choose not to elect a Company-provided medical plan for you and your dependents, the Company will credit you $100 per month.

Please note:

- You must have equivalent medical coverage under another medical plan if you elect the Medical Opt-Out Option. Be sure to review the other medical plan's provisions to confirm that this decision is right for you and your family.
- During the year, if you experience a Qualified Family Status Change that would allow you to drop your medical coverage, documentation must be provided that you have medical coverage. A signed affidavit obtained from your Human Resources representative serves as proof. This is ***not*** required during open enrollment or if you are a new hire.

If a husband and wife are American Water Works employees, the Medical Opt-Out Option is not available.

Plan Comparison Chart

Below is a comparison of benefits for the Managed Choice, HMO Elect Choice, and Out-of-Area Comprehensive Medical Plans.

MEDICAL	MANAGED CHOICE PLAN		HMO ELECT CHOICE	OUT-OF-AREA COMPREHENSIVE
	In Network	Out-Of-Network	Effective 7/1/2002	In Network
Deductibles	None	$200 single $600 family	None	$150 single $300 family
Copayments	$15	None	$15	None
Emergency Room care (no coverage for non-emergencies)	100% after $25 copay, waived if confined	100% after $25 copay, waived if confined	100% after $35 copay, waived if confined	80% after deductible
Coinsurance	90%	70%	None	80%
Out of Pocket Limits	$1,000 single $3,000 family	$3,000 per person	None	$1,000 single $3,000 family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Preventive Care				
• Routine Physical Exams	100% after $15 copay (once per 24 months), well baby to 6 yrs	Not covered	100%after $15 copay (once per 24 months), well baby to 6 yrs	80% after deductible (once per 24 months)
• Immunizations	100% after $15 copay	Not covered	100% after $15 copay	80% after deductible
• Routine Eye and Hearing Exam	100% after $15 copay (once per 24 months)	Not covered	100% after $15 copay (once per 24 months)	80% after deductible (once per 24 months)
• Routine OB/GYN Exam	100% after $15 copay (once per year on self-referral to network provider)	Not covered	100% after $15 copay (once per year on self-referral to network provider)	80% after deductible (1per calendar yr.)
• Mammography (one baseline for ages 35-39, one per calendar yr over age 40)	100% after $15 copay	Not covered	100%	80% after deductible
Physician and Hospital Services				
• Office Visits	100% after $15 copay	70% after deductible	100% after $15 copay	80% after deductible
• Specialists	100% after $15 copay	70% after deductible	100% after $15 copay	80% after deductible
• Allergy Testing	100% after $15 copay	70% after deductible	100% after $15 copay	80% after deductible
• Diagnostic X-ray and Lab	100% after $15 copay (copay applies in office; no copay for independent lab)	70% after deductible	100% after $15 copay (copay applies in office; no copay for independent lab)	80% after deductible
• Hospital Inpatient Services	90%	70% after deductible, plus $250 per confinement	100% after $100 copay per confinement	80% after deductible
• Hospital Outpatient Services	100%	70% after deductible	100%	80% after deductible
• Ambulance	90% if certified by PCP	70% after deductible (if medically necessary)	100%, no copay	80% after deductible
• Outpatient Pre-Admission Testing	100%	70% after the deductible	100%	80% after deductible
Hospital Alternatives				
• Home Health Care (120 visits per calendar year)	90%	70% after deductible	100%	80% after deductible
• Private Duty Nursing	90% for 70 8-hour shifts per yr.	After deductible, 70% for 70 shifts per yr.	100% for 70 8-hour shifts per yr.	80% after deductible
• Skilled Nursing/ Convalescent Facility	90% for 120 days	After deductible, 70% for 120 days	100% for 60 days	After deductible, 80% up to maximum 120 days per confinement
• Hospice Inpatient	90% for 90 day lifetime maximum	After deductible, 70% for 90 day lifetime maximum	100% for 90 day lifetime maximum	After deductible, 80% for 90 day lifetime maximum

MEDICAL	MANAGED CHOICE PLAN		HMO ELECT CHOICE	OUT-OF-AREA COMPREHENSIVE
• Hospice Outpatient	90% up to $5,000 lifetime maximum	After deductible, 70% up to $5,000 lifetime maximum	100% up to $5,000 lifetime maximum	After deductible, 80% up to $5,000 lifetime maximum
• Durable Medical Equipment	90% if ordered by PCP	70% after deductible	100% if ordered by PCP	80% after deductible
■ Short Term Rehabilitation	90% for 60 days per year if certified by PCP (for acute conditions only)	After deductible, 70% for 60 days per yr (for acute conditions only)	100% after $15 copay for 60 days per year if certified by PCP (for acute conditions only)	80% after deductible
Mental Health and Chemical Dependency				
• Inpatient Alcohol/Drug Treatment (coverage for employee and dependents)	90% to maximum 45 days	After deductible, 70% for 45 days per yr., up to $250 per confinement	After $100 copay per confinement, 100% to maximum 2 courses of treatment	After deductible, 80% for 45 days per yr.
■ Outpatient Alcohol/Drug treatment (coverage for employee and dependents)	After $20 copay, 100% for 20 visits per yr.	After deductible, 50% for 20 visits per year	100%	80% (no deductible) up to $500; 50% (after deductible) for expenses aver $500
■ Inpatient Treatment of Mental and Nervous Conditions	90% for 45 days per yr. (must be precertified)	After deductible, 70% for 45 days per yr.	100% for 45 days per yr. (must be precertified)	80% after deductible
■ Outpatient Treatment of Mental and Nervous Conditions	After $20 copay, 100% for 20 visits per yr.	After deductible, 50% for 20 visits per year	After $25 copay, 100% for 20 visits per yr.	80% (no deductible) up to $500; 50% (after deductible) for expenses over $500

Please note:

All maximums are combined for mental health and chemical dependency expenses. Also, mental health and chemical dependency amounts do *not* apply to your out-of-pocket maximum.

These charts display only a general description of your benefits under each of your American Water Works plan options. Should there be a conflict between the benefits shown on the charts and those described in the legal plan documents, the terms of the legal documents will be used to determine coverages and benefits.

Employees who have an HMO other than Elect Choice should obtain a package from Human Resources containing a summary of benefits.

Summary of Benefits – Peoria, IL Open Choice (PPO)

PLAN FEATURES	PREFERRED BENEFITS In-Network	NON-PREFERRED BENEFITS Out-Of-Network
Deductibles	None	$200 single $600 family
Out of Pocket Limits	$1,000 single $3,000 family	$3,000 per person
Lifetime Maximum Benefit	Unlimited	Unlimited
Physician and Hospital Services (Except Mental Health/ Chemical Dependency)		
• Office Visits (non-surgical)	100% after $15 copay	70% after deductible
• Specialists (office visits)	100% after $15 copay	70% after deductible
• Allergy Testing and Treatment (by Physician)	100% after $15 copay	70% after deductible
• Diagnostic X-ray and Lab (other than Physician's Office)	100%	70% after deductible
• Hospital Inpatient Services	90% (semi-private room)	70% after deductible, plus $250 per confinement
• Outpatient Surgery and Related Charges	100%	70% after deductible
• Emergency Room Care (no coverage for non-emergencies)	100% after $25 copay, waived if confined	100% after $25 deductible, waived if confined
• Ambulance	80%	80%
• Physician In-Hospital Services	90%	70% after deductible
Preventive Care		
• Routine Exams – Under Age 7 (well baby- 6 visits per year; 2 visits second year; 1 visit per year to age 7)	100% after $15 copay	Not covered
• Routine Exams – Age 7+ (1 routine exam per 24 months; 1 routine exam per year for age 65+)	100% after $15 copay	Not covered
• Immunizations	100% after $15 copay	Not covered
• Routine OB/GYN Exam (1 routine exam per 12 months, including Pap smear and related fees)	100% after $15 copay	Not covered
• Mammography (one baseline for ages 35-39, one per calendar yr over age 40)	100% after $15 copay	Not covered
Hospital Alternatives		
• Home Health Care	80% (120 visits per yr.) *	80% (120 visits per yr.) *
• Private Duty Nursing	80% for 70 8-hour shifts per yr. *	80% for 70 shifts per yr.
• Skilled Nursing/ Convalescent Facility	80% for 60 days per yr. *	80% for 60 days
• Hospice Inpatient	80% for 90 day lifetime maximum	80% for 90 day lifetime maximum
• Hospice Outpatient	80% up to $5,000 lifetime maximum	80% up to $5,000 lifetime maximum
• Durable Medical Equipment	80% if ordered by PCP	80% after deductible
Mental Health and Chemical Dependency		
• Inpatient Coverage	90% for 45 days per yr. (2 courses of treatment per lifetime)	After deductible and $250 per confinement copay, 70% for 45 days per yr.

PLAN FEATURES	PREFERRED BENEFITS	NON-PREFERRED BENEFITS
• Outpatient Coverage	After $20 copay, 100% for 20 visits per yr.	After deductible, 50% for 20 visits per year
• Prescription Drugs		
• Retail Program (34-day supply)	10% generic copay 20% brand-name copay	80% (no deductible) at non-participating pharmacy
• Mail Order Program (90-day supply from Express Scripts)	$5 generic copay $15 brand-name copay	Not covered
Inpatient Precertification and Concurrent Review	Provider initiated	Member initiated
Penalty for Failure to Precertify	None	First $150 per occurrence not covered
Claim Submission	Provider initiated	Member initiated

* ***Please note:*** Coverage maximums up to a certain number of days/visits per calendar year are reached by combining either preferred or non-preferred benefits up to the limit for one or the other, but not both. Example: if preferred benefit is for 60 days and non-preferred benefit is for 60 days the maximum benefit is 60 days, not 120 days.

Non-preferred benefits may be reduced if you fail to precertify inpatient admissions and certain procedures and tests. For a list of these procedures, contact Member Services.

This is only a brief summary of the preferred and non-preferred benefits available through Open Choice. Some restrictions may apply. For more specific information about the coverage details, including limitations, exclusions **and** other plan requirements, please contact Member Services.

Your Contributions

The contribution schedule for the Managed Choice, HMO Elect Choice, and Out-of-Area Comprehensive Medical Plans is shown below.

Monthly Cost for Managed Choice / HMO (including dental benefits)*		
Calendar Year	**Single**	**Family**
2002	$15.00	$40.00
2003	$18.00	$45.00
2004	$20.00	$50.00
2005	$22.00	$55.00

Rates are subject to change. If an employee resides in an area where Managed Choice is not available, contributions for the Out-of-Area Comprehensive Medical Plan will be paid at the Managed Choice rate, but the benefit levels will reflect the Out-of-Area Comprehensive Medical Plan. Upon the death of an active employee, American Water Works will pay for the cost of this coverage for the surviving spouse and dependent children for 18 months. This time period will count toward the 36-month COBRA period.

* ***These contributions also apply to other HMOs throughout American Water Works***

Enrolling for Medical Coverage

When you enroll in a medical plan, you are automatically enrolled in American Water Works Dental end Prescription Drug Plans. You also have the option of declining medical and dental coverage for yourself or your eligible dependents.

When enrolling for medical coverage, you will need to complete an American Water Works Benefit Enrollment Form if you want to participate in either:

- The Managed Choice Plan,
- The HMO Elect Choice, or
- The Out-of-Area Comprehensive Medical Plan
- The Medical Opt-Out Option

If you are newly hired and you want to enroll in a medical plan, you must return your completed enrollment form to your Human Resources office within 31 days of your eligibility date. Your eligibility date is the first day of the month following completion of one full month of continuous employment.

If you do not submit the completed form, you will not he enrolled in the Medical Opt-Out Option and will not receive the $100 payment per month. You will not be able to enroll into a medical plan until the next Open Enrollment period.

The annual Open Enrollment Period is an important opportunity to review your coverage levels and make changes to meet your benefit needs for the next Plan Year.

Coverage levels are defined as "Single" or "Family." "Eligible Family" is defined as yourself, your spouse, and any eligible dependents.

All plans provide reasonable access to primary care, specialists, and network hospitals. The standard for distance from an employee's home to a Primary Care Physician which is accepting new patients is as follows:

	Urban Area	**Rural Area**
Adult Physician *(includes Family Practice and General Internal Medicine)*	3 in 8 miles	2 in 12 miles
Pediatrician	2 in 8 miles	2 in 12 miles
OB/GYN	2 in 8 miles	2 in 12 miles
Hospital	1 in 10 miles	1 in 15 miles

Qualified Family Status Changes

You may enroll in a Plan as a new hue or during the annual Open Enrollment period. However, if you or your family have a qualified family status change, you may add or drop dependents consistent with the qualified event. **You must contact your Human Resources Department to notify them of your Qualified Family Status Change within 31 days after the change has occurred. A** new benefit form must be completed.

Note: A Qualified Family Status Change does not allow you to change your current medical plan. A Medical Plan is defined as Managed Choice, HMO Elect Choice, or the Out-of-Area Comprehensive Plan.

A "qualified family status change" occurs if;

- A child is born or adopted.
- Your spouse or child dies.
- **A** stepchild or foster child joins your family.
- You get married.
- You get divorced or legally separated.*
- You change from full-time to part-time employment
- You change from part-time to full-time employment.
- You take an unpaid leave of absence.
- You return from an unpaid leave of absence.
- Your dependent child marries.*
- Your dependent child loses his or her eligibility (i.e., reaches his or her 19th birthday—or 23rd birthday if he or she is a full-time student—or graduates from college before reaching his or her 23rd birthday).*
- You become disabled.
- Your spouse loses his or her job.
- You receive a "Qualified Medical Child Support Order (QMCSO)." See page 122 for more details.
- You may change your plan if you move to a service area where your current medical plan is not available.

These events could result in an immediate loss of eligibility for dependents.

The Managed Choice Plan

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The Managed Choice Plan

The Plan is self-insured by American Wafer Works. Aetna provides certain administrative services under the Plan.

The Managed Choice Plan is a point-of-service plan that offers both in-network and out-of-network coverage. The level of benefits you receive depends on whether or not your care is coordinated by your Primary Care Physician (PCP). The Plan is self-insured by American Water Works. When a company pays claims using its own funds, the plan is considered to be "self-insured." Aetna provides certain administrative services under the Plan. The Managed Choice Plan emphasizes preventive care, and provides employees with access to higher levels of benefits.

For you to receive the advantages of the Managed Choice Plan, your care must be provided or coordinated by a PCP. PCPs include general practitioners, family practitioners, internists, and pediatricians from your own community. If you live in a designated area and enroll in the Plan, you and each covered member of your family select a PCP. To learn which physicians are in the network, call Aetna at **(800) 292-**4366 or log on to the Aetna website at www.aetna.com and click on DocFind.

Your PCP provides you with the type of care traditionally provided by a trusted family doctor who knows your health history and is concerned about each aspect of your health care needs and preferences. If you need specialized care or advice, your PCP will refer you to an appropriate network specialist.

How the Managed Choice Plan Works

With Managed Choice, you first choose a Primary Care Physician (PCP) from a "network" of health care providers. Your PCP will either provide or coordinate your medical care. When your PCP coordinates your care:

- You receive a higher level of reimbursement for your medical expenses than you would receive if you chose a physician not in the network,
- You do not have to meet an annual deductible, and
- Your PCP or other in-network healthcare providers file all your claims.
- Your PCP initiates all required precertification.
- No claims to file,
- You will not experience any reduction in benefits under the "reasonable and customary" rule because health care providers in the network are allowed to charge only the special rates that Aetna has negotiated with them. (See the Glossary for a definition of "reasonable and customary charge.")

You may receive an annual OB/GYN exam from a network provider without a referral from your PCP.

You must contact your Primary Care Physician before you receive any medical care in order to receive the preferred level of benefits under the Managed Choice Plan, except in the following situations:

- Once a year, you may receive an annual OB/GYN exam from a network provider without a referral from your PCP. To learn which physicians are in the network, call Aetna at **(800) 292-4366** or log on to the Aetna website at www.aetna.com and click on DocFind.

  Expenses incurred for one routine OB/GYN exam given by a Preferred Care Provider without referral by your Primary Care Physician will be considered a Covered Medical Expense.
- Contact with your Primary Care Physician may take place after medical care is given to treat an "emergency condition," as defined in this Summary Plan Description.

Under the Managed Choice program, you may still receive care from any provider you choose (just as you could under a traditional plan), this is called going out of network, but if you do:

- You will have to meet an annual deductible,
- Your level of benefits reimbursable will be lower,
- You will have to file your own claims,

- You will need to initiate precertification for inpatient hospitalization and certain outpatient procedures, and
- You will be responsible for any expenses in excess of "reasonable and customary charges."

Choosing a Primary Care Physician (PCP)

*You may change your PCP at any time by calling Member Services, toil-free, at **(800) 292-4366**.*

As a participant in the Managed Choice program, you can select a Primary Care Physician (PCP) by accessing the Aetna website at www.aetna.com or by calling Aetna at **(800) 292-4366.**

You select a PCP for yourself and for each participating family member, either someone who is close to home, work or someone whose office hours are convenient for you.

Because different members of your family may need different types of health care, the network includes a variety of PCPs:

- Family practitioners and general practitioners have expertise in family care, with an emphasis on preventive medicine and health management.
- Internists have expertise in adult internal medicine.
- Pediatricians have expertise in the treatment of children.

Each member of your family may have a different PCP. For instance, you may choose an internist for yourself and a pediatrician for your children. However, each PCP must be chosen from among those listed on the Aetna website at www.aema.com or by calling Aetna at **(800) 292-4366.**

When You Need a Specialist

If you need specialized care, your PCP will refer you to a specialist in the Managed Choice network. Remember, in order to receive the highest level of benefits, you must use a specialist who belongs to the network and your PCP must refer you to him or her. There are three exceptions to this rule:

- Once a year, you may choose an obstetrician or gynecologist from the Aetna website at www.aema.com or by calling Aetna at **(800) 292-4366** and make an appointment directly with him or her for a routine gynecological exam.
- Once every 24 months, you may receive **a** complete, routine eye exam from an ophthalmologist or optometrist participating in the Managed Choice network.
- If you need medical service or treatment that is not available within the Managed Choice network, your PCP may recommend a specialist who does not belong to the network. In this case, your PCP must obtain precertification from Aetna and you'll receive the higher level of benefits.

Summay of Managed Choice Advantages

You and each covered family member select a PCP from among those listed on the Aetna website at www.aetna.com or by calling **(800) 292-4366.** When you need care, you may choose to receive...

Care provided or coordinated by your PCP (In-Network)	or	Care NOT provided or coordinated by your PCP (Out-of-Network)
Call your PCP first. The PCP will either treat you or refer you to an in-network specialist.		Call a doctor other than your PCP. The doctor will either treat you or refer you to another doctor.
The plan pays higher benefits.		The plan pays lower benefits.
You don't need to file claims.		You must file claims yourself.
If precertification is required, your PCP will handle it for you.		If precertification is required, you must start the process yourself.
You do not need to worry about "reasonable and customary" limits.		You must pay all charges in excess of "reasonable and customary" limits.

Coverage for Dependents Who Live Outside the Network Area

If your child is away at school, you should select a PCP from the area where you live and routine care may be arranged during school breaks.

The Managed Choice option has special provisions to meet the needs of any of your covered dependents who live outside the network area. In general, when selecting PCPs for your out-of-area children, consider these guidelines:

- If your child is away at school, you should select a PCP from the area where you live and routine care may be arranged during school breaks. If your child needs medical care during the school year, he or she should visit the school infirmary and call the in-network PCP for a referral to a local physician or hospital. Benefits will be paid at the in-network level.
- If your child lives permanently outside the network area (with another parent or stepparent, for example) your child may visit any doctor in the local area, and benefits will be paid at the out-of-network level. Or, if you are enrolled in Managed Choice, and a Managed Choice network is available in that area, your child may select a PCP from the local network and receive the higher level of benefits. Call Member Services at **(800) 292-4366**.
- Covered Medical Expenses for dependents covered under this Plan who permanently reside outside the Service Area include the types of expenses listed under Non-Preferred Care. Benefits will be paid at 70%, after deductible, except that Outpatient Treatment of Alcoholism, Drug Abuse, and Mental Disorders will be paid at 50%. There is no coverage for Routine Physical Exam Expenses, Routine Eye Exam Expenses, and Routine Hearing Exam Expenses.

Coverage When You're Away From Home

In a non-emergency situation, always call your PCP first.

If you're away from home (out of a Managed Choice network area) and you need medical care in a non-emergency situation, you should call your PCP. He or she will certify the care you need so that you can get the higher level of benefits. If you get health care without calling your PCP first, the Plan pays only the lower level of benefits.

In Case of Emergency

An emergency is a sudden and unexpected life-threatening medical condition that requires immediate medical or surgical care.

In case of emergency, get the care you need from the nearest health care facility or physician. Then, contact your PCP to authorize and follow up on your care. A life-threatening medical emergency is defined as "a sudden and unexpected life-threatening medical condition that requires immediate medical or surgical care in order to prevent death or a severe health crisis." Examples include convulsions, excessive bleeding, serious bums, and suspected heart attack

You will be paid at the Plan's higher benefit level for emergency care – 24 hours a day, *365* days a year – whether you are at home or away. When you need emergency care, it's important that you don't delay seeking immediate care at the nearest appropriate facility. Just remember to call your PCP (or have someone do so on your behalf) within 48 hours – or not later than the next business day if the emergency occurs on a Friday or Saturday – ***after*** you receive the care. If you fail to call your PCP, you will be eligible only for "out-of-network" benefits, after meeting the annual deductible.

When You Get Care on Your Own

The Managed Choice program also lets you arrange health care on your own, without going through your PCP. This is called self-referral. However, when you self-refer, you will have to pay a larger share of the cost of your care, even if you self-refer to a network provider. You will also have to:

- Satisfy an annual deductible.
- Pay for the services rendered.

  File a claim form each time you self-refer in order to receive reimbursement.
- Call Member Services to precertify hospital or other facility admissions and certain surgical procedures and treatments (see page 27 for a list of these procedures and treatments). If you do not follow precertification procedures, your benefits will be reduced.

Precertification

Precertification is an important feature of the Managed Choice Plan. Your PCP coordinates your care and will obtain any necessary precertification. However, if you elect to get care from an out-of-network provider – bypassing your PCP – you will have to initiate the precertification process yourself. In order to receive the highest level of benefits available, you must contact Aetna Member Services at **(800) 292-4366** to precertify any hospital admissions and certain outpatient surgical procedures, treatments, and tests. The purpose of this process is to review the medical necessity of a procedure and to approve an appropriate length of stay.

What Procedures Must Be Precertified

Precertification is required for:

- All hospital and convalescent facility admissions.
- Home health care, hospice care, and skilled nursing care.
- Inpatient treatment for substance abuse and mental disorders.
- Certain outpatient surgeries, treatments, and tests. These include:
  - Allergy immunotherapy
  - Bunionectomy
  - Carpal tunnel surgery
  - Colonoscopy
  - Coronary angiography
  - CT scan – spine
  - Dilation and curettage (D&C)
  - Hemorrhoidectomy
  - Knee arthroscopy
  - Laparoscopy (pelvic)
  - MRI – knee
  - MRI – spine
  - Septorhinoplasty
  - Tympanostomy tube
  - Upper gastrointestinal endoscopy

How to Request Precertification for a Medical Procedure or Admission

To request precertification of an admission or procedure, call the precert telephone number listed on your ID card, or call Aetna Member Services, toll-free, at **(800) 292-4366** to be directed to the Patient Management site for your area.

To request precertification of an out-of-network admission or procedure, just call the precert telephone number listed on your ID card or Aetna Member Services, toll-free, at **(800) 292-4366.** You should call at least 14 days before any scheduled admission or outpatient procedure, or as soon as you're aware that you need medical care. In case of emergency, you or a family member should contact Aetna Member Services within 48 hours after the admission or procedure.

When you call, you will speak to a Nurse Consultant who will ask you:

- Your name and Social Security number,
- The relationship of the patient to you,
- What type of surgical procedure or test you need,
- The name and telephone number of your doctor, and
- When the procedure is scheduled.

The Nurse Consultant will review the medical necessity of the proposed inpatient admission, the proposed surgical procedures and treatments, or the proposed inpatient treatment for substance abuse and mental disorders. He or she will compare information about your case with generally accepted medical standards.

Mental Health and Substance Abuse admissions are precertified by Magellan at (800) 424-4047.

If, in accordance with such standards, the proposed inpatient admission or treatment is medically necessary, it will be certified by the Nurse Consultant. On the other hand, if other treatment is more appropriate, alternative treatment settings may be suggested.

There Is A Penalty If You Don't Precertify

If you do not call Aetna Member Services to precertify a hospital admission or any of the procedures or tests listed, you will be responsible for a separate $150 penalty charge, in addition to your deductible, before benefits are paid for covered services. This penalty charge will not be applied toward your deductible or your out-of-pocket limit.

If Your Hospital Stay Is Longer Than Expected

If your hospital stay is longer than the approved period, you must notify Aetna Member Services as soon as you are aware of the need to extend your length of stay. The Nurse Consultant can then work with your doctor to extend the certification of your hospital stay.

Precertification Requirements for Non-Preferred Care

Failure to precertify will result in a $150 reduction in benefits.

You must obtain precertification for the following types of Non-Preferred Care to avoid a reduction in benefits paid for that care:

- Hospital Admissions
- Treatment Facility Admissions
- Convalescent Facility Admissions
- Home Health Care Expenses
- Hospice Care Expenses and Skilled Nursing Care

Failure to precertify will result in a $150 reduction in benefits. This is known as the "Excluded Amount," which applies separately to each type of expense listed above.

Understanding Your Share of Medical Expenses

American Water Works Medical Plans have been carefully designed to provide quality care and the most value from each dollar spent by you and the Company. It is important that you understand bow we share the costs of these valuable benefits.

Deductibles

A deductible is the amount you must pay before the Plan begins to pay benefits for covered expenses. All deductibles are calculated on an annual basis and must be met every year. The Managed Choice Plan deductibles apply only to services that are not coordinated by your PCP. Copayments do not count toward meeting the annual deductibles.

- **Calendar Year Deductible –** $200

  This Calendar Year Deductible applies to all expenses incurred for Non-Preferred Care and for care for dependents that permanently reside outside the Service Area covered under this Plan.

- Family Deductible Limit – $600

An added benefit may be paid if:

- Covered Medical Expenses are incurred by persons in your family,
- These expenses are applied against the separate Calendar Year Deductibles, and
- In a calendar year, they exceed the Family Deductible Limit.

The added benefit is 70% of the amount that exceeds the Family Deductible Limit. It does *not* count against any person's Maximum Benefit.

Inpatient Hospital Deductible

This is the amount you pay for each hospital confinement. The Inpatient Hospital Deductible will be applied only once to each hospital confinement, regardless of cause, which is separated by less than 10 days from another confinement.

Expenses used to meet the Inpatient Hospital Deductible cannot be used to meet any other applicable deductible. Expenses used to meet any other applicable deductible cannot be used to meet the Inpatient Hospital Deductible.

- Inpatient Hospital Deductible – $250 per confinement

  This Inpatient Hospital Deductible applies to Inpatient Hospital confinements, including Inpatient Alcoholism, Drug Abuse, and Mental Disorder confinements incurred for Non-Preferred Care and for care for dependents who permanently reside outside the Service Area covered under this Plan.

  However, for a confinement of a well newbom child that starts on the day of birth, the Inpatient Hospital Deductible will not exceed the hospital's actual charge for board and room for the first day of confinement on which the child's coverage is in force. To maintain continuous coverage on the newbom, you must add him/her to the Plan as a dependent within 31 days of birth.

- Emergency Room Deductible – $25

  This Emergency Room Deductible applies to Hospital Expenses incurred for emergency care provided by a Non-Preferred Care Provider and for care for dependents who permanently reside outside the Service Area covered under this Plan.

Copayments and Coinsurance

After you meet the applicable annual deductible, you and the Company share the remaining expenses through a copayment (copay) or coinsurance.

After you meet the applicable annual deductible, you and the Company share the remaining expenses through a copay.

Under the Managed Choice Plan, when you visit your PCP or other network providers, your share of the cost is referred to as a copayment. This copay is a flat fee for certain network services. If you are admitted to a network hospital or hospital alternative, generally you will be covered at 90%. You are responsible for the remaining 10%, up to the annual out-of-pocket expense limit.

Your in-network coinsurance and copayment amounts do not apply to your out-of-network deductible and coinsurance limits. Also, deductibles and coinsurance limits are higher if you choose out-of-network care.

A separate Hospital Emergency Room copay of $25 applies to each visit for emergency care to a hospital's emergency room. This copay will be waived if the person is admitted to the hospital as an inpatient immediately following a visit to a hospital emergency room.

Out-of-Pocket Limits

There is a limit to the share of medical expenses you have to pay during each calendar year. This expense amount is known as the "out-of-pocket" limit.

Copayments and deductibles do ***not*** count toward these out-of-pocket limits. If you reach your out-of-pocket limit within a calendar year, your covered expenses will be paid at 100% for the remainder of that year. If you do not reach your out-of-pocket limit, you must start accumulating expenses over again, beginning at $0 each January.

However, any expense not determined to be a covered expense as well as mental health and chemical dependency charges, and precertification penalties cannot be applied to your out-of-pocket limit.

Lifetime Maximum Benefit

The Managed Choice Plan provides an unlimited Lifetime Maximum Benefit for you and each covered member of your family.

Your Contributions

American Water Works pays the majority of your medical and dental benefits costs.

Your share of the cost (your contribution) of your benefits is paid each pay cycle, through convenient ***pretax*** payroll deductions. *Pretax* means that your contributions are withheld before federal (and in most cases, state and local) income and FICA taxes are withheld. This reduces your taxable income and the amount of tax you pay. As a result, the impact of your contribution on your take-home pay is substantially reduced. Please refer to page 16 for the contribution schedule.

Benefits Payable

After any applicable deductible or copay amount, the benefits paid under this Plan in a calendar year are paid at the Payment Percentage that applies to the type of Covered Medical Expense that is incurred, except for any different benefit level that may be described later in this Summary Plan Description. If any expense is covered under one type of Covered Medical Expense, it cannot be covered under any other type. The Payment Percentage applies after any deductible or copay amounts.

If a hospital or other health care facility does not separately identify the specific amounts of its room and board charges and its other charges, your Plan will use the following allocations for the purposes of calculating your benefits:

- Room and board charges 40%
- Other charges 60%

Payment Limits

The following limits apply to Covered Medical Expenses except:

- Expenses applied against any deductible or copay amount.
- Expenses incurred for the effective treatment of alcoholism or drug abuse, or for the treatment of mental disorders, while not confined as a full-time inpatient.

For a Person

When a person's Covered Medical Expenses incurred for Preferred Care, for which no benefits are paid because of the Payment Percentage, reach $1,000 in a calendar year, benefits will be payable at 100% for his/her Covered Medical Expenses to which this limit applies and which are incurred for Preferred Care in the rest of that calendar year.

When a person's Covered Medical Expenses incurred for Non-Preferred Care, for which no benefits are paid because of the Payment Percentage, reach $3,000 in a calendar year, benefits will be payable at 100% for his/her Covered Medical Expenses to which this limit applies and which are incurred for Non-Preferred Care in the rest of that calendar year.

For a Family

When a family's Covered Medical Expenses incurred for Preferred Care, for which no benefits are paid because of the Payment Percentage, reach $3,000 in a calendar year, benefits will be payable at 100% for their Covered Medical Expenses to which this limit applies and which are incurred for Preferred Care in the rest of that calendar year.

- There is no family out-of-pocket limit for Non-Preferred Care expenses. Individual out-of-pocket limits will apply.

Benefit Maximums

All maximums included in this Plan are combined maximums between Preferred Care and Non-Preferred Care, where applicable, unless specifically stated otherwise.

The following limitations apply to some of the benefits under the Managed Choice Plan:

- **Convalescent Care**
  60 days per calendar year
- **Maximum Private Duty Nursing Care**
  70 eight-hour shifts per calendar year
- **Home Health Care**
  120 visits per calendar year (a "visit" is considered to be four hours or less in duration)
- **Hospice Care**
  90 days Inpatient per calendar year
  $5,000 Outpatient Lifetime Maximum
- **Short-Term Rehabilitation**
  60 days per calendar year if certified by PCP
- **Private Room Limit**
  The institution's semi-private rate
- **Lifetime Maximum Benefit**
  Unlimited

Covered Expenses

Inpatient Hospital Care

Charges made by a hospital for providing room, board, and other hospital services and supplies for a person who is confined as a full-time inpatient are covered. They must be for the treatment of an injury or illness.

Inpatient admissions must be precertified to qualify for the maximum benefit payable.

For Preferred Care

If a private room is used, the daily room and board charge is covered if the person's Preferred Care Provider requests the private room and the request is approved by Aetna.

If these procedures are not met, any part of the daily board and room charge which is more than the Private Room Limit is not covered.

For Nan-Preferred Care

Not included is any charge for daily room and board in a private room over the Private Room Limit.

Outpatient Hospital Care

Charges made by a hospital for hospital services and supplies which are provided for a person who is not confined as a full-time inpatient are covered.

Convalescent Facility Care

Precertification of convalescent facility services is necessary to receive the maximum benefit payable by the Plan.

Charges made by a convalescent facility for the following services and supplies are covered. They must be furnished to a person while confined to convalesce from an illness or injury.

- Room and Board. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any charge for daily board and room in a private room over the Private Room Limit.
- Use of special treatment rooms
- X-ray and lab work
- Physical, occupational, or speech therapy
- Oxygen and other gas therapy
- Other medical services usually given by a convalescent facility. This does not include private or special nursing, or physicians' services.
- Medical supplies

The Plan does not cover convalescent facility charges made for treatment of

- Drug addiction
- Chronic brain syndrome
- Alcoholism
- Senility
- Mental retardation
- Any other mental disorder

Home Health Care

Home health care visits are limited to 120 in a calendar year. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.

Home health care expenses are covered if:

- The charge is made by a home health care agency,
- The care is given under a home health care plan, and
- The care is given to a person in his or her home.

Home health care expenses are charges for:

- Part-time or intermittent care by an R.N., or by an L.P.N. if an R.N. is not available.
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational, and speech therapy.
- The following expenses are covered to the extent they would have been covered under this Plan if the person had been confined in a hospital or convalescent facility:
  - medical supplies, drugs, and medicines prescribed by a physician; and
  - lab services provided by or for a home health care agency.

There is a maximum of 120 visits covered in a calendar year. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.

The Plan does not cover charges made for:

- Services or supplies that are not a part of the home health care plan.
- Services of a person who usually lives with you or is a member of your or your spouse's family.
- Services of a social worker.
- Transportation.

Routine Physical Exams

The charges made by your Primary Care Physician for a routine physical exam given to you, your spouse. or your dependent child may be included as Covered Expenses.

The charges made by your Primary Care Physician for a routine physical exam given to you, your spouse, or your dependent child are included in Covered Medical Expenses.

A routine physical exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified injury or illness. Included are:

- X-rays and laboratory and other tests given in connection with the exam, and
- Materials for the administration of immunizations for infectious illness and testing for tuberculosis.

To qualify as a covered physical exam, the physician's exam must include at least:

- A review and written record of the patient's complete medical history,
- A check of all body systems, and
- A review and discussion of the exam results with the patient or with the parent or guardian.

For all exams given to your child under age six, Covered Medical Expenses will include charges for:

- Up to six exams in the first year of the child's life,
- Up to two exams in the second year of the child's life, and
- One exam per year during the next four years of the child's life.

For all exams given to your child age six and over, Covered Medical Expenses will not include charges for more than one exam in a period of 24 consecutive months.

For all exams given to you or your spouse, Covered Medical Expenses will not include charges for more than one exam in a period of 24 consecutive months.

Not covered are charges for:

- Services and supplies furnished by a Non-Preferred Health Care Provider,
- Services which are covered to any extent under any other part of this Plan or any other group plan sponsored by American Water Works,
- Services which are for diagnosis or treatment of a suspected or identified injury or illness,
- Exams given while the person is confined in a hospital or other place for medical care,
- Services not given by a physician or under his or her direction,
- Medicines, drugs, appliances, equipment, or supplies,
- Psychiatric, psychological, personality, or emotional testing or exams,
- Exams in any way related to employment,
- Premarital exams,
- Vision, hearing, or dental exams, or
- A physician's office visit in connection with immunization or testing for tuberculosis.

Routine Eye Exams

Your American Water works Plan covers one routine eye exam every 24 months.

Covered Medical Expenses include charges for a complete eye exam, including refraction that is furnished by a legally qualified ophthalmologist or optometrist participating in the Managed Choice network. You do not need a referral from your PCP.

Covered Medical Expenses will not include charges for more than one eye exam in a period of 24 consecutive months.

Not included are charges for:

- Any eye exam to diagnose or treat an illness or injury,
- Drugs or medicines,
- Any services or supplies which are included as covered expenses under any other benefit section included in this Plan or under any other plan of group benefits provided through American Water Works.
- Any services or supplies for which benefits are provided under any Workers' Compensation law or any other law of similar purpose, whether benefits are payable for all or only part of the charges,
- Any service or supply which does not meet professionally accepted standards,
- Any service or supply received while the person is not covered,
- Any exams given while the person is confined in a hospital or other facility for medical care,
- Any eye exam required by an employer as a condition of employment, or that an employer is required to provide under a labor agreement or that is required by any law of a government, or
- Any service or supply furnished by a Non-Preferred Health Care Provider.

Routine Hearing Exams

Your American Water Works Plan covers a routine hearing exam by a participating provider once every 24 months.

Covered Medical Expenses include charges for an audiometric exam. The services must be performed by a Managed Choice network physician who is certified as an otolaryngologist or otologist, or by an audiologist who either:

- Is legally qualified in audiology, or
- Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements, and
- Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

Covered Medical Expenses will not include charges for more than one hearing exam in a period of 24 consecutive months.

Not included are charges for:

- Any ear or hearing exam to diagnose or treat an illness or injury,
- Drugs or medicines,

- Any hearing care service or supply which is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through American Water Works,
- Any hearing care service or supply for which a benefit is provided under any Workers' Compensation law or any other law of like purpose, whether benefits are payable for all or only part of the charges,
- Any hearing care service or supply which does not meet professionally accepted standards,
- Any service or supply received while the person is not covered,
- Any exams given while the person is confined in a hospital or other facility for medical care,
- Any exam required by an employer as a condition of employment, or that an employer is required to provide under a labor agreement or that is required by any law of a government, or
- Any service or supply furnished by a Non-Preferred Health Care Provider.

Routine Pap Smear

Covered Medical Expenses include charges incurred for one routine Pap smear and related laboratory expenses each calendar year.

Routine Mammogram

Covered Medical Expenses include charges incurred by a female age 35 or over for a routine mammogram as follows, provided you have a referral from your Primary Care Physician:

- One baseline mammogram, if the person is at least age 35 but less than 40;
- One mammogram each calendar year, if the person is age 40 or over.

Women's Health and Cancer Rights Act

On October 21,1998, a new federal law, the Women's Health and Cancer Rights Act, became effective. The law requires group health plans that provide coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies. We are pleased to inform you that Aetna is already in compliance with the law.

The law mandates that a member receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy, will also receive coverage for:

- Reconstruction of the breast on which the mastectomy has been performed

- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymphedemas

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

Family Planning

The charges made by a physician or hospital for a vasectomy or tubal ligation for voluntary sterilization, even though not incurred in connection with the diagnosis or treatment of an illness or injury, are Covered Medical Expenses. Not covered are charges for the reversal of a sterilization procedure.

Annual Gynecological Exam

You may visit your Managed Choice network gynecologist once a year for a routine exam. without a referral from your PCP.

Expenses incurred for one routine gynecological exam given by a Preferred Care Provider without referral by your Primary Care Physician will be considered a Covered Medical Expense. Charges for one self-referred exam per calendar year will be paid at the preferred level of benefits. Any subsequent visits or treatment must be on referral by your Primary Care Physician in order for the preferred level of benefits to apply to that care. The routine gynecological exam, including one Pap smear and related laboratory expenses, is considered Office Care. No coverage is provided if the exam is given by a Non-Preferred Care Provider.

Pregnancy

Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for an illness.

Pregnancy expenses must be incurred while the person is covered under this Plan. If expenses are incurred after the coverage ceases, they will be considered for benefits only if satisfactory evidence is furnished to Aetna that the person has been totally disabled since her coverage terminated.

Any pregnancy benefits payable by previous group health coverage will be subtracted from health benefits payable for the same expenses under this Plan.

Coverage for abortions is limited to those abortions performed because the life of the mother would be in danger if the fetus were carried to term and to those abortions which result in medical complications.

Mouth, Jaws, and Teeth

The Medical Plan covers certain treatments of the mouth, jaws and teeth only in the event of injury. Treatment must be of, or related to, the teeth, mouth, jaws, jaw joints, or supporting tissues (these include bones, muscles, and nerves).

The Medical Plan will cover certain expenses only in the event of injury. Charges for root canal therapy; routine tooth removal (which does not involve cutting of the bone); and in-mouth appliances, crowns, bridgework, dentures, tooth restorations, and any related fitting or adjustment services (whether or not their purpose is to relieve pain) are covered if they are required as the result of injury to the mouth, jaw, or teeth.

The Medical Plan does not cover charges to remove, repair, replace, restore, or reposition teeth which are lost or damaged in the course of biting or chewing. Charges to repair, replace, or restore fillings, crowns, dentures, or bridgework are not covered by the Medical Plan. Non-surgical periodontal treatment is excluded, as are charges for dental cleaning; in-mouth scaling, planing, or scraping; and myofunctional therapy (muscle training therapy to correct or control harmful habits).

The following services and supplies furnished for the treatment of the mouth, jaws, jaw joints, teeth, and supporting tissues (including bones, muscles. and nerves) are Covered Medical Expenses and not part of the Dental Plan. For these expenses, "physician" includes a dentist; however, they require a PCP referral in order to be covered under the Medical Plan.

- Surgery needed to treat a fracture, dislocation, or wound or to cut out teeth partly or completely impacted in the bone of the jaw. Covered surgery may cut out teeth that will not erupt through the gum, as well as other teeth that cannot be removed without cutting into bone.
- Also covered are surgeries that cut out the roots of a tooth without removing the entire tooth, as well as removing cysts, tumors, or other diseased tissues while cutting into the gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement, or repair of teeth. Covered surgery may also alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- Non-surgical treatment of infections or illnesses. This does not include those of or related to the teeth.
- Dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition natural teeth damaged, lost or removed, and other body tissues of the mouth fractured or cut due to injury. The accident causing the injury must occur while the person is covered under the Medical Plan.

  Any such teeth must have been free from decay or in good repair and firmly attached to the jawbone at the time of the injury.

The treatment must be done in the calendar year of the accident or the next one.

If crowns (caps), dentures (false teeth), bridgework, or in-mouth appliances are installed due to such injury, Covered Medical Expenses include only charges for the following:

- the first denture or fixed bridgework to replace lost teeth,
- the first crown needed to repair each damaged tooth, and
- an in-mouth appliance used in the first course of orthodontic treatment after the injury.

Except as provided for injury, the Medical Plan does not cover charges for in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services, whether or not the purpose of such services or supplies is to relieve pain. In addition, the Medical Plan does not cover root canal therapy or routine tooth removal (not needing cutting of the bone).

Skilled Nursing Care

Coverage for private duty nursing is limited to 70 shifts per calendar year. Each period of private duty nursing of up fo 8 hours will be considered one private duty nursing shift.

The charges made by an R.N. or L.P.N. or a nursing agency for "skilled nursing services" are included as Covered Medical Expenses. No other charges made by an R.N. or L.P.N. or a nursing agency are covered. As used here, "skilled nursing services" means these services:

- Visiting nursing care by an R.N. or L.P.N. Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.
- Private duty nursing by an R.N. or L.P.N. if the person's condition requires skilled nursing care and visiting nursing care is not adequate.

Benefits will not be paid during a calendar year for private duty nursing for any shifts in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private duty nursing of up to eight hours will be considered one private duty nursing shift.

Not included as "skilled nursing care" is:

- That part or all of any nursing care that does not require the education, training, and technical skills of an R.N. or L.P.N., such as transportation, meal preparation, charting of vital signs, and companionship activities;
- Any private duty nursing care, given while the person is an inpatient in a hospital or other health care facility;
- Care provided to help a person in the activities of daily life, such as bathing, feeding, personal grooming, dressing, getting in and out of a bed, chair, or toileting;
- Care provided solely for skilled observation, excluding one period per day of up to 4 hours for no more than 10 consecutive days following the occurrence of:

- a change in patient medication,
- the need for urgent or emergency medical services provided by a physician or the
- onset of symptoms indicating the likely need for such services.
- surgery, or
- release from inpatient confinement;

- Any service provided solely to administer oral medicines, except where applicable law requires that such medicines be administered by an R.N. or L.P.N.

Hospice Care

Charges made for the following inpatient services furnished to a person for hospice care when given as a part of a Hospice Care Program are included as Covered Medical Expenses.

The Plan covers inpatient or outpatient hospice care for an individual who has been diagnosed as having six months or less to live.

Inpatient Care

Room and board and other services and supplies furnished to a person while a full-time inpatient for pain control and other acute and chronic symptom management.

Not included is any charge for daily room and hoard in a semi-private room over the Private Room Limit. Inpatient hospice care is limited to a total of 90 days for all confinements.

Inpatient hospice care must be precertified to be covered at the highest level payable by the Plan.

Facility and Physician Expenses

The Plan covers charges made on its own behalf by a:

- Hospice facility
- Hospital
- Convalescent facility or
- Physician

Outpatient Care

Outpatient hospice care is subject to a lifetime maximum of $5,000.

The Plan covers charges made by a Hospice Care Agency for the following outpatient services and supplies, if they are precertified up to a lifetime maximum of $5,000.

- Part-time or intermittent nursing care by an R.N. or L.P.N. for up to eight hours in any one day.

- Medical social services under the direction of a physician. These include:
  - assessment of the person's social, emotional, and medical needs, and the home and family situation;
  - identification of the community resources which are available to the person;
  - assisting the person to obtain those resources needed to meet the person's assessed needs.
- Psychological and dietary counseling.
- Consultation or case management services by a physician,
- Physical and occupational therapy.
- Part-time or intermittent home health aide services for up to eight hours in any one day. These consist mainly of caring for the person.
- Medical supplies, drugs, and medicines prescribed by a physician.

Charges made by the providers below for Outpatient Care, but only if the provider is not an associate of a Hospice Care Agency and such agency retains responsibility for the care of the person:

- A physician for consultant or case management services.
- A physical or occupational therapist.
- A Home Health Care Agency for:
  - physical or occupational therapy;
  - part-time or intermittent home health aide services for up to eight hours in any one day (these services consist mainly of caring for the person);
  - medical supplies, drugs, and medicines prescribed by a physician;
  - psychological and dietary counseling.

Not included are charges made:

- For bereavement counseling
- For funeral arrangements
- For pastoral counseling
- For financial or legal counseling. These include estate planning or the drafting of **a** will.
- For homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill to other members of the family, transportation, housecleaning, and maintenance of the house.

- For respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

Short-Term Rehabilitation

Short-Term Rehabilitation is therapy which is expected to result in the improvement of a body function (Including the restoration of the level of an existing speech function) which has been lost or impaired due to an injury, an illness, or a congenital defect.

You and your covered dependents are covered for a maximum of 60 days of Short-Term Rehabilitation services during a calendar year as long as the treatment is certified by your PCP.

The charges made by:

- A physician, or
- A licensed or certified physical, occupational, or speech therapist,

for Short-Term Rehabilitation services to treat acute conditions arc Covered Medical Expenses.

Short-term rehabilitation services consist of:

- Physical therapy,
- Occupational therapy, or
- Speech therapy,

furnished to a person who is not confined as an inpatient in a hospital or other facility for medical care. This therapy shall be expected to result in significant improvement of the person's condition within ***60*** days from the date the therapy begins.

The charges for Short-Term Rehabilitation services are Covered Medical Expenses for no longer than the Short-Term Rehabilitation Maximum Days for each person during any one calendar year.

Not covered are charges for.

- Services which are covered to any extent under any other part of this Plan.

  Any services which are covered expenses in whole or in part under any other group plan sponsored by an employer.

- Services received while the person is confined in a hospital or other facility for medical care.

- Services not performed by a physician or not under his direct supervision.

  Services rendered by a physical, occupational, or speech therapist who resides in the person's home, or who is a part of the family of either the person or the person's spouse.

  Services rendered for the treatment of delays in speech development, unless resulting from:

  - illness,
  - injury, or
  - congenital defect.

- Special education including lessons in sign language, to instruct a person whose ability to speak has been lost or impaired to function without that ability.
- Any services not provided in accordance with a specific treatment plan that:
  - Details the treatment to be rendered and the frequency and duration of the treatment.
  - Provides for ongoing reviews and is renewed only if therapy is still necessary.

Emergency Care

In the event of a medical emergency, the Plan covers treatment in the emergency room of a hospital.

If treatment is received in the emergency room of a hospital while a person is not a full-time inpatient, and the treatment is emergency care, Covered Medical Expenses for charges made by the hospital for such treatment will be paid at the Payment Percentage.

"Emergency care" means the first treatment given in a hospital's emergency room right after the sudden and, at that time, unexpected onset of a change in a person's physical or mental condition that requires hospital level care because:

- The care could not safely and adequately have been provided other than in a hospital, or
- Adequate care was not available elsewhere in the area at the time and place it was needed, and
- If the hospital level care were not given could, as determined by Aetna, reasonably be expected to result in:
  - loss of life, limb or
  - significant impairment to bodily function or

    permanent dysfunction of a body part.

Nan-Emergency Care

If treatment is received in the emergency room of a hospital while a person is not a full-time inpatient and the treatment is not emergency care, no benefits will be paid.

Other Covered Medical Expenses

Other covered medical expenses include:

- Charges made by a physician.
- Diagnostic lab work and X-rays.
- X-ray, radium, and radioactive isotope therapy.
- Anesthetics and oxygen.
- Rental of durable medical or surgical equipment. Not included are charges for more than one item of equipment for the same or similar purpose.

- "Durable Medical and Surgical Equipment" is equipment that is made to withstand prolonged use and to be used mainly in the treatment of an illness or injury. It must be suited for use in the home and not normally of use to persons who do not have an illness or injury. Such equipment shall not be used in altering air quality or temperature, or for exercise or training.

The purchase, repair, or replacement of durable medical and surgical equipment and accessories needed to operate it.

The initial purchase of such equipment and accessories is covered only if Aetna is shown that long term use is planned and the equipment cannot be rented, or it is likely to cost less to buy it than to rent it.

Repair or replacement of such purchased equipment and accessories. Replacement will be covered only if Aetna is shown that it is needed because of a change in the person's physical condition, or it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.

Artificial limbs and eyes (however, eyeglasses, hearing aids, orthopedic shoes, or other devices to support the feet are not included).

Professional ambulance service to transport a person from the place where he is injured or stricken by illness to the first hospital where treatment is given.

Pre-Existing Conditions

Pre-Existing Conditions do not apply under any Aetna Plan.

Certification for Hospital Admissions

Inpatient hospital confinements must be precertified to qualify for the highest level of benefits paid by the Plan. If precertification is not obtained, benefits will be reduced or denied.

Covered Medical Expenses incurred on any day not certified during the confinement will be paid as follows if:

- A person becomes confined in a hospital as a full-time inpatient, and
- It has not been certified that such confinement (or any day of such confinement) is necessary, and
- The confinement has not been ordered and prescribed by:
  - your Primary Care Physician, or
  - a Preferred Care Provider upon referral by your Primary Care Physician.

Hospital Expenses Incurred During the Confinement

If certification has been requested and denied for part of the confinement, no benefits will be paid for Hospital Expenses incurred for room and board for that day(s). Benefits for all other Hospital Expenses will be paid at the Payment Percentage.

If certification has not been obtained, medically necessary expenses will be paid at the lower benefit level.

Other Hospital Expenses

Expenses, up to the Excluded Amount (such as the deductible or any applicable penalty), will not be deemed to be Covered Medical Expenses. Benefits for such expenses in excess of the Excluded Amount will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is necessary, Hospital Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses. Benefits for all other Hospital Expenses will be payable at the Payment Percentage.

Other Covered Medical Expenses

*Call the precert number on your ID card or Aetna Member Services at **(800) 292-4366** to obtain certification of a hospital inpatient admission. Written notice of the number of days certified will be sent promptly to the hospital. A copy will be sent to you and the physician.*

Benefits will be paid at the Payment Percentage.

Whether or not a day of confinement is certified, no benefit will be paid for expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan, except that, if certification has been given for a day of confinement, the exclusion of services and supplies because they are not necessary will not he applied to expenses for hospital room and board.

In the event of an urgent admission, you, the person's physician, or the hospital must call Aetna Member Services for certification before the person is confined as a full-time inpatient.

An urgent admission is the result of an injury caused by an accident, the diagnosis of an illness, or the onset of, or change in, an illness. The person's condition does not require emergency medical care, but is severe enough to require confinement in a hospital within two weeks of the date the physician determines that confinement is required.

A "non-urgent admission" is one which is not an emergency admission or an urgent admission.

When a covered person is confined as a full-time inpatient as the result of an emergency admission, you, the person's physician, or the hospital must call Aetna Member Services to request certification within 48 hours of the start of the confinement. If the physician cannot request certification within 48 hours, the call must be made as soon as reasonably possible. The 48 hour requirement is extended to 72 hours when the confinement starts on a Friday or Saturday.

An admission is considered to be an emergency when the physician admits the person to the hospital right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental condition which could be life threatening or result in significant impairment or permanent dysfunction if the person is not immediately confined as a full-time hospital inpatient.

If, in your physician's opinion, it is necessary for you to be confined for a longer time than already certified, you, the physician, or the hospital may request that more days be certified by calling the precert number on your ID card or Aetna Member Services at **(800) 292-4366.** This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the hospital. A copy will be sent to you and the physician.

Certification for Convalescent Facility Care, Home Health Cave, Hospice Care, and Skilled Nursing Care

Precertification is required for confinements in a convalescent facility or hospice facility. and for home health care and outpatient hospice care. If precertification is not obtained, benefits may be reduced.

Covered Medical Expenses will be paid as follows if incurred:

- While a person is confined in a convalescent facility or a hospice facility; or

  For a service or a supply for home health care, hospice care, or skilled nursing care when a person is not confined as an inpatient; and

- It has been certified that such confinement or care is necessary; and
- The confinement or care has been ordered and prescribed by:
  - your Primary Care Physician, or
  - a Preferred Care Provider upon referral by your Primary Care Physician.

Facility Expenses

If certification has been requested and denied, no benefits will be paid for Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for board and room. Benefits for all other Convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is not necessary, no benefits will be paid for Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for board and room. As to all other Convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement:

- Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.
- Benefits for all other such expenses will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is necessary, convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses. Benefits for all other such expenses incurred during the confinement will be paid at the Payment Percentage. As to all other Covered Medical Expenses incurred during the confinement, benefits will be paid at the Payment Percentage.

Expenses for Services or Supplies

To get certification you must call the precert number on your ID card or Aetna Member Services at ***(800) 292-4366.*** *Such certification must be obtained before an expense is incurred. Prompt written notice will be provided to you of the days of confinement and services or supplies which have been certified.*

If certification for a service or supply has been requested and denied or if certification has not been requested and the service or supply is not necessary, no benefits will be paid for the denied or unnecessary service or supply.

If certification has not been requested for a service or supply and the service or supply is necessary, benefits for the necessary service or supply will be paid as follows:

- Expenses incurred for the service or supply, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.
- Benefits for all other Covered Medical Expenses incurred for the service or supply will be paid at the Payment Percentage.

Whether or not a day of confinement or a service or supply has been certified, no benefit will be paid if the charges for such confinement or service or supply are excluded by any other terms of this Plan, except that, to the extent that a day of confinement has been certified, the exclusion of services and supplies because they are not necessary will not apply to:

- Convalescent Facility Expenses for room and board, or
- Hospice Care Facility Expenses for room and board.

To the extent that such service or supply has been certified for home health care, hospice care, or skilled nursing care, the exclusion of services or supplies because they are not necessary will not apply to such service or supply.

If a person's physician believes that the person needs more days of confinement or services or supplies beyond those which have been already certified you must call to certify more days of confinement or services or supplies.

Prompt written notice will be provided to you of the days of confinement and services or supplies which have been certified.

If services and supplies for hospice care provided to a person have been certified and the person later requires confinement in **a** hospital for pain control or acute symptom management, any other certification requirement in this Plan will be waived for any such day of confinement in a hospital.

Certification for Certain Procedures and Treatments

Certification of the necessity of certain procedures and treatments is required:

- Before the procedure is performed, or
- Before the treatment starts, unless such procedure or treatment has been ordered and prescribed by:
- Your Primary Care Physician, or
- A Preferred Care Provider upon referral by your Primary Care Physician.

When any of the procedures or treatments shown below are to be performed on an inpatient or outpatient basis, Covered Medical Expenses incurred in connection with the performance of the procedure or treatment will be payable as follows:

- If the procedure or treatment is not necessary, no benefits will be payable whether or not certification has been requested.
- If certification has been requested and the procedure or treatment is necessary, benefits will be payable at the Payment Percentage.
- If certification has not been requested and the procedure or treatment is necessary, expenses incurred in connection with its performance, up to the Excluded Amount, will not be considered to be Covered Medical Expenses. Benefits for Covered Medical Expenses in excess of the Excluded Amount will be payable at the Payment Percentage.

Certification for certain procedures and treatment is required when they are performed on either an inpatient or outpatient basis.

The following procedures or treatments require certification before they are performed, regardless of whether done on an inpatient or outpatient basis.

- Allergy immunotherapy
- Bunionectomy
- Carpal tunnel surgery
- Colonoscopy
- Coronary angiography
- CT scan – spine
- Dilation and curettage (D&C)
- Hemorrhoidectomy
- Knee arthroscopy
- Laparoscopy (pelvic)

- MRI – knee
- MRI – spine
- Septorhinoplasty
- Tympanostomy tube
- Upper gastrointestinal endoscopy

You, or the provider performing the procedure or treatment, must call the precert number on your ID card or Aetna Member Services at **(800) 292-4366** to request certification.

If the procedure or treatment is performed due to an Emergency Condition, the call must be made:

- Before the procedure or treatment is performed, or
- Not later than 48 hours after the procedure or treatment is performed, unless the call cannot be made within that time. In that case, the call must be made as soon as it is reasonably possible. In the event the procedure or treatment is performed on a Friday or Saturday, the 48-hour requirement will be extended to 72 hours.

If the procedure or treatment is performed for any condition other than an Emergency Condition, the call must be made at least 14 days before the date the procedure is to be performed or the treatment is to start. If it is not possible to make the call during the specified time, it must be made as soon as reasonably possible before the date the procedure or treatment is to be performed.

Written notice of the certification decision will be sent promptly to you and the provider performing the procedure or treatment. This decision will be valid for 60 days from the date you receive the notice. If the procedure or treatment is to be performed after this 60 day period, certification must again be requested, as described above.

Certification for Hospital and Treatment Facility Admissions for Alcoholism, Drug Abuse, or Mental Disorders

Precertification is required for inpatient admissions to treat alcoholism, drug abuse, and mental disorders. Benefits may be reduced if certification is not obtained.

Covered Medical Expenses for the effective treatment of alcoholism, drug abuse, or mental or nervous disorders will be paid as follows if incurred:

- While a person is confined in a hospital or treatment facility, and
- It has not been certified that such confinement is necessary, and
- The confinement has not been ordered and prescribed by:
  - your Primary Care Physician, or
  - a Preferred Care Provider upon referral by your Primary Care Physician.

Facility Room and Board Expenses

If certification has been requested and denied, or if certification bas not been requested and the confinement (or any day of it) is not necessary, no benefits will be paid.

If certification has not been requested and the confinement is necessary, such expenses, up to the Excluded Amount, will not be considered Covered Medical Expenses.

Other Facility Expenses Incurred for the Services of a Physician

If certification has been requested and denied, or if certification has not been requested and the confinement is necessary, such expenses, up to the Excluded Amount, will not be considered Covered Medical Expenses.

If certification has not been requested and the confinement is not necessary, no benefits will be paid.

Whether or not a day of confinement is certified, no benefits will be payable for Covered Medical Expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan, except that, if certification has been given for any day of confinement, the exclusions of services and supplies because they are not necessary will not be applied to hospital and treatment facility room and board.

To request certification, you must call the *precert* number on your ID card or Aetna Member Services at (800) ***292-4366.*** *Such* certification *must* be obtained before confinement as a full-time inpatient, or in *the* case of Emergency Care, *within* 48 hours after the *start* of e *confinement* as a ***full-*** time inpatient or as soon *as* reasonably possible.

"Emergency Care" means the first treatment given in a hospital's emergency room for the sudden and unexpected onset of a change in a person's physical or mental condition which:

- Requires hospital level care because the care could not safely and adequately have been provided other than in a hospital, or
- Adequate care was not available elsewhere in the area at the time and place it was needed, and
- If hospital level care were not given could, as determined by Aetna, reasonably be expected to result in:
  - loss of life or limb, or
  - significant impairment to bodily function, or
  - permanent dysfunction of a body part.

If the person's physician believes that the person needs more days of confinement beyond those which have already been certified, additional days of confinement must be certified. This must be done no later than on the last day that has already been certified.

Treatment of Alcoholism, Drug Abuse, or Mental Disorders

Inpatient Treatment

If a person is a full-time inpatient either in a hospital or treatment facility, then the coverage is as shown below.

Expenses for the following are covered:

- Treatment of the medical complications of alcoholism or drug abuse, such as cirrhosis of the liver, delirium tremens, or hepatitis.
- Effective treatment of alcoholism or drug abuse.
- Treatment of a mental disorder.
- Room and Board. Not covered is any charge for daily room and board in a private room over the Private Room Limit.
- Other necessary services and supplies.

Such expenses are covered:

- If they are incurred during the first 45 days of all such confinements during any one calendar year.
- For alcoholism and drug abuse, benefits will he paid for only two courses of treatment during your lifetime.

Benefits will be paid at the Payment Percentage.

Outpatient Treatment

Expenses incurred for the effective treatment of alcoholism or drug abuse or the treatment of mental disorders while the person is not confined as a full-time inpatient in a hospital or treatment facility will be considered Covered Medical Expenses.

Benefits will be paid at the Payment Percentage. Benefits will not be paid for more than the Special Outpatient Calendar Year Maximum Visits in any one calendar year.

Submitting Claims

You should file your claim(s) during the calendar year in which the service or treatment was provided.

All claims must be filed within two years from the date of the incurred expense. Your claims must be in writing, and you must give proof of the nature and extent of the expense. You may obtain Medical Plan Benefits Request forms from your Human Resources representative.

How Your Benefits Are Paid

American Water Works has contracted with Aetna to assist in administering benefits under the Managed Choice Plan, as the Claims Administrator. Your claims will be paid as soon as Aetna receives the necessary written proof supporting your claim. In order to speed claims processing, Aetna will pay medical benefits directly to the provider unless you specify that you want the benefits paid to you. If you are a minor, or otherwise legally unable to give a valid release, Aetna may make payment to any of your relatives whom it determines to be fairly entitled to the payment.

With the exception of the copayment for physician office visits, you should never pay a provider directly until you receive an EOB.

How to File a Medical Claim

When you use your PCP, you will not have to complete a Medical Plan Benefits Request form. Your PCP will handle all claim filing for you.

Fast processing of your out-of-network claim depends on complete, accurate information on your Benefits Request form. When filing a claim, please remember to:

- Complete all applicable sections of your Benefits Request form Any unanswered questions will cause delay in processing your claim;
- Be sure to include your Social Security number on all claims, including claims for your dependent(s). Also be sure to sign the form; and
- Attach the itemized bill to the form. An itemized bill must include the following information:
  - the patient's full name,
  - the patient's relationship to you,
  - the date service was provided,
  - the name of the health care professional providing service,
  - the provider's taxpayer identification number,
  - the type of service provided,
  - the nature of the illness or injury, and
  - the charges for the service or treatment (multiple expenses should be itemized).

If any of this information is missing, write it on the bill yourself and sign your name. Your health care provider should complete the physician/supplier section of the claim form if he or she has not given you an itemized statement.

If you have "other group" or Medicare coverage that pays benefits prior to American Water Works Plan, you will need to provide Aetna with a copy of the other carrier's EOB reflecting the benefits paid under the other coverage on the expenses being submitted for payment under the Managed Choice Plan.

Once you have completed the Medical Plan Benefits Request form and attached the itemized bills, send everything to:

Aetna
P.O. Box 3929
Allentown, PA 18106-9861

If you have any questions about the status of your claim, call Aetna Member Services at **(800) 292-4366.**

The HMO Elect Choice Plan

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The HMO Plan

The Plan is self-insured by American Water Works. Aetna provides certain administrative services under the Plan.

The HMO Elect Choice Plan is an in-network plan. The Plan is self-insured by American Water Works. When a company pays claims using its own funds, the plan is considered to he "self-insured." Aetna provides certain administrative services under the Plan. The HMO Elect Choice Plan emphasizes managed care, and provides employees with access to the highest levels of benefits.

For you to receive the advantages of the HMO Elect Choice Plan, your care must be provided or coordinated by a Primary Care Physician (PCP). PCPs include general practitioners, family practitioners, internists, and pediatricians from your own community. If you live in a designated area and enroll in the Plan, you and each covered member of your family select a PCP. To learn which physicians are in the network, call Aetna at **(800) 292-4366** or log on to the Aema's website at www.aetna.com and click on DocFind. When prompted to select a Health Plan on the wehsite, choose Elect Choice EPO.

Your PCP provides you with the type of care traditionally provided by a trusted family doctor who knows your health history and is concerned about each aspect of your health care needs and preferences. If you need specialized care or advice, your PCP will refer you to an appropriate network specialist.

How the HMO Elect Choice Plan Works

With the HMO Elect Choice Plan, you must choose a Primary Care Physician (PCP) from a "network" of health care providers. Your PCP will either provide or coordinate your medical care. When your care is coordinated by your PCP:

- You receive the highest level of reimbursement for your medical expenses,
- You do not have ***to meet*** an annual deductible, and
- All claims are filed for you by your PCP or other in-network health care providers.
- Your PCP initiates all required precertification.

You may receive an annual OB/GYN exam from a network provider without a referral from your PCP.

You must contact your Primary Care Physician before you receive any medical care, however;

- You may receive an annual OB/GYN exam from a network provider without a referral from your PCP. To learn which physicians are in the network, call Aetna at (800) 292-4366 or log on to the Aetna's website at www.aetna.com and click on DocFind.
- In an emergency, go to the nearest emergency facility. If a delay would not be harmful to your health call your PCP. Notify Member Services as soon as possible after treatment.

Choosing a Primary Care Physician (PCP)

*You may change your PCP at any time simply by calling Member Services, toll-free, at **(800) 292-4366**.*

As a participant in the HMO Elect Choice program, you must select a Primary Care Physician (PCP) by accessing the Aetna's website at www.aetna.com or by calling Aetna at **(800) 292-4366.** When prompted to select a Health Plan on the website, choose Elect Choice EPO.

You select a PCP for yourself and for each participating family member, either someone who is close to home or work or someone whose office hours are convenient for you. Because different members of your family may need different types of health care, the network includes a variety of PCPs:

- Family practitioners and general practitioners have expertise in family care, with an emphasis on preventive medicine and health management.
- Internists have expertise in adult internal medicine.
- Pediatricians have expertise in the treatment of children.

Each member of your family may have a different PCP. For instance, you may choose an internist for yourself and a pediatrician for your children. However, each PCP must be chosen from among those listed on the Aetna's website at www.aetna.com or by calling Aetna at **(800) 292-4366.**

You may change your PCP at any time simply by calling Member Services, toll-free, at **(800) 292-4366.**

When You Need A Specialist

If you need specialized care, your PCP will refer you to a specialist in the HMO Elect Choice network. Remember, in order to receive the highest level of benefits, you must use a specialist who belongs to the network, and your PCP must refer you to him or her. There are three exceptions to this rule:

- Once a year, you may choose an obstetrician or gynecologist from the Aetna's website at www.aetna.com or by calling Aetna at (800) **292-4366** and make an appointment directly with him or her for a gynecological exam.
- Once every **24** months, you may receive a complete eye exam from an ophthalmologist or optometrist participating in the HMO Elect Choice network.

If you need medical service or treatment that is not available within the HMO Elect Choice network, your PCP may recommend a specialist who does not belong to the network. In this case, your PCP must obtain precertification from Aetna and you'll receive the higher level of benefits.

Summary of HMO Elect Choice Advantages

- You and each covered family member select a PCP from the Aetna's website at www.aetna.com or by calling Aetna at (800) **292-4366.**
- When you need care, call your PCP first. Care will be provided or coordinated by your PCP (In-Network). The PCP will either treat you or refer you to an in-network specialist.
- The plan pays higher benefits,
- You don't need to file claims,
- If precertification is required, your PCP will handle it for you,
- You do not need to worry about "reasonable and customary" limits.

Coverage for Dependents Who Live Outside the Network Area

If your child is away at school, you should select a PCP from the area where you live and routine care may be arranged during school breaks.

The HMO Elect Choice option has special provisions to meet the needs of any of your covered dependents that live outside the network area. In general, when selecting PCPs for your out-of-area children, consider these guidelines:

If your child is away at school, you should select a PCP from the area where you live and routine care may be arranged during school breaks. If your child needs medical care during the school year, he or she should visit the school infirmary, or call the in-network PCP for a referral to a local physician or hospital. That way, benefits will be paid at the in-network level.

Coverage When You're Away From Home

In a non-emergency situation, always call your PCP first.

If you're away from home (out of the HMO Elect Choice network area) and you need medical care in a situation that is not an emergency, you should call your PCP. He or she will certify the care you need so that you can get the higher level of benefits. If you get health care without calling your PCP first, the services will not he covered by Aetna.

In Case of Emergency

An emergency is a sudden and unexpected life-threatening medical condition that requires immediate medical or surgical care.

In case of emergency, get the care you need from the nearest health care facility or physician. Then, contact your PCP to authorize and follow up on your care. A life-threatening medical emergency is defined as "a sudden and unexpected life-threatening medical condition that requires immediate medical or surgical care in order to prevent death or a severe health crisis." Examples include convulsions, excessive bleeding, serious bums, and suspected heart attack. When you need emergency care, it's important that you don't delay seeking immediate care at the nearest appropriate facility. Just

remember to call your PCP (or have someone do so on your behalf) within 48 hours – or not later than the next business day if the emergency occurs on a Friday or Saturday – *after* you receive the care. If you fail to call your PCP, the services will not be covered by Aetna.

Precertification

Certain services must be precertified with the HMO Elect Choice Plan. Your PCP will coordinate your care and obtain any necessary precertification. The purpose of this process is to review the medical necessity of a procedure and to approve an appropriate length of stay.

What Procedures Must Be Precertified

Precertification is required for:

- All hospital and convalescent facility admissions.
- Home health care, hospice care, and skilled nursing care.
- Inpatient treatment for substance abuse and mental disorders.
- Certain outpatient surgeries, treatments, and tests. These include:
  - Allergy immunotherapy
  - Bunionectomy
  - Carpal tunnel surgery
  - Colonoscopy
  - Coronary angiography
  - CT scan – spine
  - Dilation and curettage (D&C)
  - Hemorrhoidectomy
  - Knee arthroscopy
  - Laparoscopy (pelvic)
  - MRI – knee
  - MRI – spine
  - Septorhinoplasty
  - Tympanostomy tube
  - Upper gastrointestinal endoscopy

If Your Hospital Stay Is Longer Than Expected

If your hospital stay is longer than the approved period, you must notify Aetna Member Services as soon as you are aware of the need to extend your length of stay. The Nurse Consultant can then work with your doctor to extend the certification of your hospital stay.

Copayments

Under the HMO Elect Choice Plan, when you visit your PCP your share of the cost is referred to as a copayment. Your share of the cost is $15 and the Plan pays 100% thereafter.

A separate Hospital Emergency Room copay of $35 applies to each visit for emergency care to a hospital's emergency room. This copay will be waived if the person is admitted to the hospital as an inpatient immediately following a visit to a hospital emergency room.

Lifetime Maximum Benefit

The HMO Elect Choice Plan provides an unlimited Lifetime Maximum Benefit for you and each covered member of your family

Your Contributions

American Water Works pays the majority of your medical and dental benefits costs.

Your share of the cost (your contribution) of your benefits is paid each pay cycle, through convenient *pretax* payroll deductions. *Pretax* means that your contributions are withheld before federal (and in most cases, state and local) income and FICA taxes are withheld. This reduces your taxable income and the amount of tax you pay. As a result, the impact of your contribution on your take-home pay is substantially reduced. Please refer to page 16 for the contribution schedule.

Covered Expenses

Home Health Care

You must obtain precertification of home health care to receive the maximum benefit payable by the Plan.

Home health care visits are limited to 120 in a calendar year. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.

Home health care expenses are covered if:

- The charge is made by a home health care agency,
- The care is given under a home health care plan, and
- The care is given to a person in his or her home

Home health care expenses are charges for:

- Part-time or intermittent care by an R.N., or by an L.P.N. if an R.N. is not available.
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational, and speech therapy.
- The following expenses are covered to the extent they would have been covered under this Plan if the person had been confined in a hospital or convalescent facility:
  - medical supplies, drugs, and medicines prescribed by a physician; and
  - lab services provided by or for a home health care agency,
- There is a maximum of 120 visits covered in a calendar year. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.

The Plan does not cover charges made for:

- Services or supplies that are not a part of the home health care plan.
- Services of a person who usually lives with you or is a member of your or your spouse's family.
- Services of a social worker.
- Transportation.

Routine Physical Exams

The charges made by your Primary Care Physician for a routine physical exam given to you, your spouse, or your dependent child are included as Covered Medical Expenses.

The charges made by your Primary Care Physician for a routine physical exam given to you, your spouse, or your dependent child may be included as Covered Expenses.

A routine physical exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified injury or illness. Included are:

- X-rays and laboratory and other tests given in connection with the exam, and
- Materials for the administration of immunizations for infectious illness and testing for tuberculosis.

To qualify as a covered physical exam, the physician's exam must include at least:

- A review and written record of the patient's complete medical history,
- A check of all body systems, and
- A review and discussion of the exam results with the patient or with the parent or guardian.

For all exams given to your child under age six, Covered Medical Expenses will include charges for:

- Up to six exams in the first year of the child's life,
- Up to two exams in the second year of the child's life, and
- One exam per year during the next four years of the child's life.

For all exams given to your child age six and over, Covered Medical Expenses will not include charges for more than one exam in a period of 24 consecutive months.

For all exams given to you or your spouse, Covered Medical Expenses will not include charges for more than one exam in a period of 24 consecutive months.

Not covered are charges for:

- Services and supplies furnished by a Non-Preferred Health Care Provider,
- Services which are covered to any extent under any other part of this Plan or any other group plan sponsored by American Water Works,
- Services which are for diagnosis or treatment of a suspected or identified injury or illness,
- Exams given while the person is confined in a hospital or other place for medical care,
- Services not given by a physician or under his or her direction,
- Medicines, drugs, appliances, equipment, or supplies,
- Psychiatric, psychological, personality, or emotional testing or exams,
- Exams in any way related to employment,

- Premarital exams,
- Vision, hearing, or dental exams, or
- A physician's office visit in connection with immunization or testing for tuberculosis.

Routine Eye Exams

Your American Water Works Plan covers one routine eye exam every 24 months.

Covered Medical Expenses include charges for a complete eye exam, including refraction that is furnished by a legally qualified ophthalmologist or optometrist participating in the HMO Elect Choice network. You do not need a referral from your PCP.

Covered Medical Expenses will not include charges for more than one eye exam in a period of 24 consecutive months.

Not included are chargesfor:

- Any eye exam to diagnose or treat an illness or injury,
- Drugs or medicines,
- Any services or supplies which are included as covered expenses under any other benefit section included in this Plan or under any other plan of group benefits provided through American Water Works.
- Any services or supplies for which benefits are provided under any Workers' Compensation law or any other law of similar purpose, whether benefits are payable for all or only part of the charges,
- Any service or supply which does not meet professionally accepted standards,
- Any service or supply received while the person is not covered,
- Any exams given while the person is confined in a hospital or other facility for medical care,
- Any eye exam required by an employer as a condition of employment, or that an employer is required to provide under a labor agreement or that is required by any law of a government, or
- Any service or supply furnished by a Non-Preferred Health Care Provider.

Routine Hearing Exams

Your American Water Works Plan covers a routine hearing exam by a participating provider once every 24 months.

Covered Medical Expenses include charges for an audiometric exam. The services must be performed by an HMO Elect Choice network physician who is certified as an otolaryngologist or otologist, or by an audiologist who either:

- Is legally qualified in audiology, or
- Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements, and

- Performs the exam at the written direction of a legally qualified otolaryngologistor otologist.

Covered Medical Expenses will not include charges for more than one hearing exam in a period of 24 consecutive months.

Not included are charges for.

- Any ear or hearing exam to diagnose or treat an illness or injury,
- Dmgs or medicines,
- Any hearing care service or supply which is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through American Water Works,

  Any hearing care service or supply for which a benefit is provided under any Workers' Compensation law or any other law of like purpose, whether benefits are payable for all or only part of the charges,

  Any hearing care service or supply which does not meet professionally accepted standards,
- Any service or supply received while the person is not covered,
- Any exams given while the person is confined in a hospital or other facility for medical care,
- Any exam required by an employer as a condition of employment, or that an employer is required to provide under a labor agreement or that is required by any law of a government, or
- Any service or supply furnished by a Non-Preferred Health Care Provider.

Routine Pap Smear

Covered Medical Expenses include charges incurred for one routine Pap smear and related laboratory expenses each calendar year.

Routine Mammogram

Covered Medical Expenses include charges incurred by a female age 35 or over for a routine mammogram as follows:

- One baseline mammogram, if the person is at least age 35 but less than 40;
- One mammogram each calendar year, if the person is age 40 or over.

Women's Health and Cancer Rights Act

On October 21, 1998, a new federal law, the Women's Health and Cancer Rights Act, became effective. The law requires group health plans that provide coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies. We are pleased to inform you that Aetna is already in compliance with the law.

The law mandates that a member receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy, will also receive coverage for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

Family Planning

The charges made by a physician or hospital for a vasectomy or tubal ligation for voluntary sterilization, even though not incurred in connection with the diagnosis or treatment of an illness or injury, are Covered Medical Expenses. Not covered are charges for the reversal of a sterilization procedure.

Annual Gynecological Exam

You may visit your HMO Elect Choice network gynecologist once a year for a routine exam, without a referral from your PCP.

You may visit your HMO Elect Choice network gynecologist once a year for a routine exam, without a referral from your PCP.

Charges for one self-referred exam per calendar year will be paid at the highest level of benefits. Any subsequent visits or treatment must be on referral by your Primary Care Physician in order for the highest level of benefits to apply to that care. The routine gynecological exam, including one Pap smear and related laboratory expenses, is considered Office Care.

Pregnancy

Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for an illness.

Pregnancy expenses must be incurred while the person is covered under this Plan. If expenses are incurred after the coverage ceases, they will be considered for benefits only if satisfactory evidence is furnished to Aetna that the person has been totally disabled since her coverage terminated.

Any pregnancy benefits payable by previous group health coverage will be subtracted from health benefits payable for the same expenses under this Plan.

Coverage for abortions is limited to those abortions performed because the life of the mother would be in danger if the fetus were carried to term and to those abortions which result in medical complications.

Mouth, Jaws, and Teeth

The Medical Plan covers ceriain treatments of the mouth, jaws and teeth only in the event of injury Treatment must be of, or related to, the teeth, mouth, jaws, jaw joints, or supporting tissues (these include bones, muscles, and nerves).

The Medical Plan will cover certain expenses only in the event of injury. Charges for root canal therapy; routine tooth removal (which does not involve cutting of the bone); and in-mouth appliances, crowns, bridgework, dentures, tooth restorations, and any related fitting or adjustment services (whether or not their purpose is to relieve pain) are covered if they are required as the result of injury to the mouth, jaw, or teeth.

The Medical Plan does not cover charges to remove, repair, replace, restore, or reposition teeth which are lost or damaged in the course of biting or chewing. Charges to repair, replace, or restore fillings, crowns, dentures, or bridgework are not covered by the Medical Plan. Non-surgical periodontal treatment is excluded, as are charges for dental cleaning; in-mouth scaling, planing, or scraping; and myofunctional therapy (muscle training therapy to correct or control harmful habits).

The following services and supplies furnished for the treatment of the mouth, jaws, jaw joints, teeth, and supporting tissues (including bones, muscles, and nerves) are Covered Medical Expenses and not part of the Dental Plan. For these expenses, "physician" includes a dentist; however, they require a PCP referral in order to be covered under the Medical Plan.

- Surgery needed to treat a fracture, dislocation, or wound or to cut out teeth partly or completely impacted in the bone of the jaw. Covered surgery may cut out teeth that will not erupt through the gum, as well as other teeth that cannot be removed without cutting into bone.

  Also covered are surgeries that cut out the roots of a tooth without removing the entire tooth, as well as removing cysts, tumors, or other diseased tissues while cutting into the gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement, or repair of teeth. Covered surgery may also alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

  Non-surgical treatment of infections or illnesses. This does not include those of or related to the teeth.

- Dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition natural teeth damaged, lost or removed, and other body tissues of the mouth fractured or cut due to injury. The accident causing the injury must occur while the person is covered under the Medical Plan.

  Any such teeth must have been free from decay or in good repair and firmly attached to the jawbone at the time of the injury.

The treatment must be done in the calendar year of the accident or the next one.

If crowns (caps), dentures (false teeth), bridgework, or in-mouth appliances are installed due to such injury, Covered Medical Expenses include only charges for the following:

- the first denture or fixed bridgework to replace lost teeth,
- the first crown needed to repair each damaged tooth, and
- an in-mouth appliance used in the first course of orthodontic treatment after the injury.

Except as provided for injury, the Medical Plan does not cover charges for in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services, whether or not the purpose of such services or supplies is to relieve pain. In addition, the Medical Plan does not cover root canal therapy or routine tooth removal (not needing cutting of the bone).

Skilled Nursing Care

The charges made by an R.N. or L.P.N. or a nursing agency for "skilled nursing services" are included as Covered Medical Expenses. No other charges made by an R.N. or L.P.N. or a nursing agency are covered. As used here, "skilled nursing services" means these services:

- Visiting nursing care by an R.N. or L.P.N. Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.
- Private duty nursing by an R.N. or L.P.N. if the person's condition requires skilled nursing care and visiting nursing care is not adequate.

Coverage for private duty nursing is limited to 70 shifts per calendar year. Each period of private duly nursing of up to 8 hours will be considered one private duty nursing shift.

Benefits will not he paid during a calendar year for private duty nursing for any shifts in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private duty nursing of up to eight hours will be considered one private duty nursing shift.

Not included as "skilled nursing care" is:

- That part or all of any nursing care that does not require the education, training, and technical skills of an R.N. or L.P.N., such as transportation, meal preparation, charting of vital signs, and companionship activities;
- Any private duty nursing care, given while the person is an inpatient in a hospital or other health care facility;
- Care provided to help a person in the activities of daily life, such as bathing, feeding, personal grooming, dressing, getting in and out of a bed ,chair, or toileting;
- Care provided solely for skilled observation, excluding one period per day of up to 4 hours for no more than 10 consecutive days following the occurrence of:

- a change in patient medication,
- the need for urgent or emergency medical services provided by a physician or the
- onset of symptoms indicating the likely need for such services.
- surgery, or
- release from inpatient confinement;

- Any service provided solely to administer oral medicines, except where applicable law requires that such medicines be administered by an R.N. or L.P.N.

Hospice Care

Charges made for the following inpatient services furnished to a person for hospice care when given as a part of a Hospice Care Program are included as Covered Medical Expenses.

The Plan coven: inpatient or outpatient hospice care for an individual who has been diagnosed as having six months or less to live.

Inpatient Care

Room and board and other services and supplies furnished to a person while a full-time inpatient for pain control and other acute and chronic symptom management.

Not included is any charge for daily room and board in a semi-private room over the Private Room Limit. Inpatient hospice care is limited to a total of 90 days for all confinements.

inpatient hospice care must be precertified to be covered at the highest ieveipayable by the Plan.

Facility and Physician Expenses

The Plan covers charges made on its own behalf by a:

- Hospice facility
- Hospital
- Convalescent facility or
- Physician

Outpatient Care

Outpatient hospice care is subject to a lifetime maximum of $5,000.

The Plan covers charges made by a Hospice Care Agency for the following outpatient services and supplies, if they are precertified up to a lifetime maximum of $5,000.

- Part-time or intermittent nursing care by an R.N. or L.P.N. for up to eight hours in any one day.
- Medical social services under the direction of a physician. These include:

- assessment of the person's social, emotional, and medical needs, and the home and family situation;
- identification of the community resources which are available to the person;
- assisting the person to obtain those resources needed to meet the person's assessed needs.

- Psychological and dietary counseling.
- Consultation or case management services by a physician.
- Physical and occupational therapy.
- Part-time or intermittent home health aide services for up to eight hours in any one day. These consist mainly of caring for the person.
- Medical supplies, drugs, and medicines prescribed by a physician.

Charges made by the providers below for Outpatient Care, but only if the provider is not an employee of a Hospice Care Agency and such agency retains responsibility for the care of the person:

- A physician for consultant or case management services.
- A physical or occupational therapist.
- A Home Health Care Agency for:
  - physical or occupational therapy;
  - part-time or intermittent home health aide services for up to eight hours in any
  - one day (these services consist mainly of caring for the person);
  - medical supplies, drugs, and medicines prescribed by a physician;
  - psychological and dietary counseling.

Not included are charges made:

- For bereavement counseling
- For funeral arrangements
- For pastoral counseling
- For financial or legal counseling. These include estate planning or the drafting of a will.
- For homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family, transportation, housecleaning, and maintenance of the house.

- For respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

Short-Term Rehabilitation

Short-Term Rehabilitation is therapy which is expected to result in the improvement of a body function (including the restoration of the level of an existing speech function) which has been lost or impaired due to an injury, an illness, or a congenital defect.

You end your covered dependents are covered for a maximum of 60 days of Short- Term Rehabilitation services during a calendar year. as long as the treatment is certified by your PCP.

The charges made by:

- A physician, or
- A licensed or certified physical, occupational, or speech therapist,

for Short-Term Rehabilitation services to treat acute conditions are Covered Medical Expenses.

Short-term rehabilitation services consist of:

- Physical therapy,
- Occupational therapy, or
- Speech therapy,

furnished to a person who is not confined as an inpatient in a hospital or other facility for medical care. This therapy shall be expected to result in significant improvement of the person's condition within 60 days from the date the therapy begins.

The charges for Short-Term Rehabilitation services are Covered Medical Expenses for no longer than the Short-Term Rehabilitation Maximum Days for each person during any one calendar year.

Not covered are charges for:

- Services which are covered to any extent under any other part of this Plan.
- Any services which are covered expenses in whole or in part under any other group plan sponsored by an employer.
- Services received while the person is confined in a hospital or other facility for medical care.
- Services not performed by a physician or not under his direct supervision.
- Services rendered by a physical, occupational, or speech therapist who resides in the person's home, or who is a part of the family of either the person or the person's spouse.
- Services rendered for the treatment of delays in speech development, unless resulting from:
  - illness,
  - injury, or
  - congenital defect.

- Special education including lessons in sign language. to instruct a person whose ability to speak has been lost or impaired to function without that ability'.

  Any services not provided in accordance with a specific treatment plan that:

  - Details the treatment to be rendered and the frequency and duration of the treatment.
  - Provides for ongoing reviews and is renewed only if therapy is still necessary.

Emergency Care

In the event of a medical emergency, the Plan covers treatment in the emergency room of a hospital.

If treatment is received in the emergency room of a hospital while a person is not a full-time inpatient, and the treatment is emergency care, you pay $35 ($0 if admitted).

"Emergency care" means the first treatment given in a hospital's emergency room right after the sudden and, at that time, unexpected onset of a change in a person's physical or mental condition that requires hospital level care because:

- The care could not safely and adequately have been provided other than in a hospital, or

  Adequate care was not available elsewhere in the area at the time and place it was needed, and

- If the hospital level care were not given could, as determined by Aetna, reasonably be expected to result in:
  - loss of life, limb or
  - significant impairment to bodily function or
  - permanent dysfunction of a body part.

Non-Emergency Care

If treatment is received in the emergency room of a hospital while a person is not a full-time inpatient and the treatment is not emergency care, no benefits will be paid.

Other Covered Medical Expenses

Other covered medical expenses include:

- Charges made by a physician.
- Diagnostic lab work and X-rays.
- X-ray, radium, and radioactive isotope therapy.
- Anesthetics and oxygen.

- Rental of durable medical or surgical equipment. Not included are charges for more than one item of equipment for the same or similar purpose.

  - "Durable Medical and Surgical Equipment" is equipment that is made to withstand prolonged use and to be used mainly in the treatment of an illness or injury. It must be suited for use in the home and not normally of use to persons who do not have an illness or injury. Such equipment shall not be used in altering air quality or temperature, or for exercise or training.

- The purchase, repair, or replacement of durable medical and surgical equipment and accessories needed to operate it.

  The initial purchase of such equipment and accessories is covered only if Aetna is shown that long term use is planned and the equipment cannot be rented, or it is likely to cost less to buy it than to rent it.

- Repair or replacement of such purchased equipment and accessories. Replacement will be covered only if Aetna is shown that it is needed because of a change in the person's physical condition, or it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.

- Artificial limbs and eyes,(however eyeglasses, hearing aids, orthopedic shoes, or other devices to support the feet are not covered).

- Professional ambulance service to transport a person from the place where he is injured or stricken by illness to the first hospital where treatment is given.

Pue-Existing Conditions

Pre-Existing Conditions do not apply under any Aetna Plan.

Certification for Hospital Admissions

Inpatient hospital confinements must be precertified to qualify for benefits.

Hospital Expenses Incurred During the Confinement

If certification has been requested and denied for part of the confinement, no benefits will be paid for the day(s) not certified.

If certification has not been requested and the confinement (or any day of such confinement) is not necessary, no benefits will be paid.

Other Covered Medical Expenses

In the event of an urgent admission, you, the person's physician, or the hospital must call the precert number on your ID card or Aetna Member Services for certification before the person is confined as a full-time inpatient.

An urgent admission is the result of an injury caused by an accident, the diagnosis of an illness, or the onset of, or change in, an illness. The person's condition does not require emergency medical care, but is severe enough to require confinement in a hospital within two weeks of the date the physician determines that confinement is required.

A "non-urgent admission" is one which is not an emergency admission or an urgent admission.

When a covered person is confined as a full-time inpatient as the result of an emergency admission, you, the person's physician, or the hospital must call the precert number on your ID card or Aetna Member Services to request certification within 48 hours of the start of the confinement. If the physician cannot request certification within

48 hours, the call must be made as soon as reasonably possible. The 48 hour requirement is extended to 72 hours when the confinement starts on a Friday or Saturday.

An admission is considered to be an emergency when the physician admits the person to the hospital right after the sudden and. at that time, unexpected onset of a change in the person's physical or mental condition which could be life threatening or result in significant impairment or permanent dysfunction if the person is not immediately confined as a full-time hospital inpatient.

If, in your physician's opinion, it is necessary for you to be confined for a longer time than already certified, you, the physician, or the hospital may request that more days be certified by calling the precert number on your ID card or Aetna Member Services at **(800) 292-4366** This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the hospital. A copy will be sent to you and to the physician.

Facility Care, Home Health Care, Hospice Care, and Skilled Nursing Care

Precertification is required for confinements in a convalescent facility or hospice facility, and for home health care and outpatient hospice care. If precertification is not obtained, services will not be covered.

Covered Medical Expenses will be paid as follows if incurred:

While a person is confined in a convalescent facility or a hospice facility; or

- For a service or a supply for home health care, hospice care, or skilled nursing care when a person is not confined as an inpatient; and
- It has not been certified that such confinement or care is necessary; and

The confinement or care has not been ordered and prescribed by:

- your Primary Care Physician, or
- a Preferred Care Provider upon referral by your Primary Care Physician.

Facility Expenses

If certification has been requested and denied, no benefits will be paid for Convalescent Facility Expenses or Hospice Care Facility Expenses.

Benefits for all other Convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is not necessary, no benefits will be paid for Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for room and board. As to all other Convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement:

- Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.
- Benefits for all other such expenses will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is necessary, convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses. Benefits for all other such expenses incurred during the confinement will be paid at the Payment Percentage. As to all other Covered Medical Expenses incurred during the confinement, benefits will be paid at the Payment Percentage.

Expenses for Services or Supplies

If certification for a service or supply has been requested and denied or if certification has not been requested and the service or supply is not necessary, no benefits will be paid for the denied or unnecessary service or supply

If certification has not been requested for a service or supply and the service or supply is necessary, benefits for the necessary service or supply will be paid as follows:

- Expenses incurred for the service or supply, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.
- Benefits for all other Covered Medical Expenses incurred for the service or supply will be paid at the Payment Percentage.

Whether or not a day of confinement or a service or supply has been certified, no benefit will be paid if the charges for such confinement or service or supply are excluded by any other terms of this Plan, except that, to the extent that a day of confmement has been certified, the exclusion of services and supplies because they are not necessary will not apply to:

- Convalescent Facility Expenses for room and board, or
- Hospice Care Facility Expenses for room and board.

*To get certification you must call the precert number on your ID card or Aeina Member Services at **(800) 292-4366.** Such certification must be obtained before an expense is incurred. Prompt written notice will be provided to you of the days of confinement and services or supplies which have been certified.*

To the extent that such service or supply has been certified for home health care, hospice care, or skilled nursing care, the exclusion of services or supplies because they are not necessary will not apply to such service or supply.

If a person's physician believes that the person needs more days of confinement or services or supplies beyond those which have been already certified you must call to certify more days of confinement or services and supplies.

Prompt written notice will be provided to you of the days of confinement and services or supplies which have been certified

If services and supplies for hospice care provided to a person have been certified and the person later requires confinement in a hospital for pain control or acute symptom management, any other certification requirement in this Plan will be waived for any such day of confinement in a hospital.

Certification for Certain Procedures and Treatments

Certification of the necessity of certain procedures and treatments is required:

- Before the procedure is performed, or
- Before the treatment starts, unless such procedure or treatment has been ordered and prescribed by:
- Your Primary Care Physician, or
- A Preferred Care Provider upon referral by your Primary Care Physician.

When any of the procedures or treatments shown below are to be performed on an inpatient or outpatient basis, Covered Medical Expenses incurred in connection with the performance of the procedure or treatment will be payable as follows:

- If the procedure or treatment is not necessary, no benefits will be payable whether or not certification has been requested.
- If certification has been requested and the procedure or treatment is necessary, benefits will be payable at the Payment Percentage.
- If certification has not been requested and the procedure or treatment is necessary, expenses incurred in connection with its

performance, up to the Excluded Amount, will not be considered to be Covered Medical Expenses. Benefits for Covered Medical Expenses in excess of the Excluded Amount will be payable at the Payment Percentage.

The following procedures or treatments require certification before they are performed, regardless of whether done on an inpatient or outpatient basis.

- Allergy immunotherapy
- Bunionectomy
- Carpal tunnel surgery
- Colonoscopy
- Coronary angiography
- CT scan – spine
- Dilation and curettage (D&C)
- Nemorrhoidectomy
- Knee arthroscopy
- Laparoscopy (pelvic)
- MRI – knee
- MRI – spine
- Septorhinoplasty
- Tympanostomy tube
- Upper gastrointestinal endoscopy

You, or the provider performing the procedure or treatment, must call the precert number on your ID card or Aetna Member Services at **(800) 292-4366** to request certification.

If the procedure or treatment is performed due to an Emergency Condition, the call must be made:

- Before the procedure or treatment is performed, or
- Not later than 48 hours after the procedure or treatment is performed, unless the call cannot be made within that time. In that case, the call must be made as soon as it is reasonably possible. In the event the procedure or treatment is performed on a Friday or Saturday, the 48-hour requirement will be extended to 72 hours.

If the procedure or treatment is performed for any condition other than an Emergency Condition, the call must be made at least 14 **days** before the date the procedure is to be performed or the treatment is to start. If it is not possible to make the call during the specified time, it must be made as soon as reasonably possible before the date the procedure or treatment is to be performed.

Written notice of the certification decision will be sent promptly to you and *the* provider performing the procedure or treatment. This decision will be valid for 60 days from the date you receive the notice. If the procedure or treatment is to be performed after this 60 day period, certification must again be requested, as described above.

Certification for Hospital and Treatment Facility Admissions for Alcoholism, Drug Abuse, or Mental Disorders

Covered Medical Expenses for the effective treatment of alcoholism, drug abuse, mental or nervous disorders will be paid as follows if incurred:

- While a person is confined in a hospital or treatment facility, and
- It has not been certified that such confinement is necessary, and
- The confinement has not been ordered and prescribed by:
  - your Primary Care Physician, or
  - a Preferred Care Provider upon referral by your Primary Care Physician.

Facility Room and Board Expenses

If certification has been requested and denied, or if certification has not been requested and the confinement (or any day of it) is not necessary, no benefits will be paid.

If certification has not been requested and the confinement is necessary, such expenses, up to the Excluded Amount, will not be considered Covered Medical Expenses.

Other Facility Expenses Incurred for the Services of a Physician

If certification has been requested and denied, or if certification has not been requested and the confinement is necessary, such expenses, up to the Excluded Amount, will not be considered Covered Medical Expenses.

*To request certification, you must call the precerf number on your ID card or Aetna Member Services at **(800) 292-4366.** Such certification must be obtained before confinement as a full-time inpatient, or in the case of Emergency Care, within 48 hours after the start of a confinement as a full-time inpatient or as soon as reasonably possible.*

If certification has not been requested and the confinement is not necessary, no benefits will be paid.

Whether or not a day of confinement is certified, no benefits will be payable for Covered Medical Expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan, except that, if certification has been given for any day of confinement, the exclusions of services and supplies because they are not necessary will not be applied to hospital and treatment facility room and board.

"Emergency Care" means the first treatment given in a hospital's emergency room for the sudden and unexpected onset of a change in a person's physical or mental condition which:

- Requires hospital level care because the care could not safely and adequately have been provided other than in a hospital, or
- Adequate care was not available elsewhere in the area at the time and place it was needed, and
- If hospital level care were not given could, as determined by Aetna, reasonably be expected to result in:
  - loss of life or limb, or
  - significant impairment to bodily function, or
  - permanent dysfunction of a body part.

If the person's physician believes that the person needs more days of confinement beyond those which have already been certified, additional days of confinement must be certified. This must be done no later than on the last day that has already been certified.

Treatment of Alcoholism, Drug Abuse, or Mental Disorders

Inpatient Treatment

If a person is a full-time inpatient either in a hospital or treatment facility, then the coverage is as shown below.

Expenses for the following are covered:

- Treatment of the medical complications of alcoholism or drug abuse, such as cirrhosis of the liver, delirium tremens, or hepatitis.

  Effective treatment of alcoholism or drug abuse
- Treatment of a mental disorder.

- Room and Board. Not covered is any charge for daily room and board in a private room over the Private Room Limit.

  Other necessary services and supplies.

Such expenses are covered:

- If they are incurred during the first 45 days of all such confinements during any one calendar year.
- For alcoholism and drug abuse, benefits will be paid for only two courses of treatment during your lifetime.

Benefits will be paid at the Payment Percentage.

Outpatient Treatment

Expenses incurred for the effective treatment of alcoholism or drug abuse or the treatment of mental disorders while the person is not confined as a full-time inpatient in a hospital or treatment facility will be considered Covered Medical Expenses.

Benefits will be paid at the Payment Percentage. Benefits will not be paid for more than the Special Outpatient Calendar Year Maximum Visits in any one calendar year.

Submitting Claims

You should file your claim(s) during the calendar year in which the service or treatment was provided.

All claims must be filed within two (2) years from the date of the incurred expense. Your claims must be in writing, and you must give proof of the nature and extent of the expense. You may obtain Medical Plan Benefits Request forms from your Human Resources representative.

How Your Benefits Are Paid

American Water Works has contracted with Aetna to assist in administering benefits under the HMO Elect Choice Plan, as the Claims Administrator. Your claims will be paid as soon as Aetna receives the necessary written proof supporting your claim. In order to speed claims processing, Aetna will pay medical benefits directly to the provider.

How to File a Medical Claim

When you use your PCP, you will not have to complete a Medical Plan Benefits Request form. Your PCP will handle all claim filing for you.

If you have "other group" or Medicare coverage that pays benefits prior to American Water Works Plan, you will need to provide Aetna with a copy of the other carrier's EOB reflecting the benefits paid under the other coverage on the expenses being submitted for payment under the HMO Elect Choice Plan.

Claims should be mailed to:

Aetna
P.O. Box 3929
Allentown, PA 18106-9861

If you have any questions about the status of your claim, call Aetna Member Services at **(800) 292-4366.**

The Out-of-Area Comprehensive Medical Plan

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How The Out-of-Area Comprehensive Medical Plan Works

The Out-of-Area Comprehensive Medical Plan option has been designed to protect you against the cost of an illness or injury. The Plan allows you to use any licensed doctor and hospital you choose. The Out-of-Area Comprehensive Medical Plan is an insured medical expense plan and is underwritten by Aetna. The provisions of the Plan will remain effective only while you are covered under the plan. You are not eligible for this plan if you live in an area where a managed care network has been established.

Understanding Your Share of Medical Expenses

American Water Works Medical Plans have been carefully designed to provide quality coverage and the most value from each dollar spent by you and the Company. It is important that you understand how we share the costs of these valuable benefits.

Deductibles

A deductible is the amount you pay before the Plan begins to pay for covered expenses. Plan deductibles are shown on the Plan Comparison Chart on pages 13-14.

All deductibles are calculated on an annual basis, and must be met every year. There is a Calendar Year Deductible that applies to each person. An expense incurred in the last three months of a calendar year which is applied against a person's Calendar Year Deductible will reduce his or her Calendar Year Deductible for the next year. Prescription Drug copayments do not count toward meeting the annual deductibles. Applicable deductibles are shown on the Plan Comparison Chart on pages 13-14.

Family Deductible Limit

This is the limit of Covered Medical Expenses that must be paid by persons in your family before the Plan begins to pay benefits. These expenses must first be applied against the separate Calendar Year Deductibles, and when such expenses exceed the Family Deductible Limit, the Plan then pays benefits at 80 percent of the remaining covered expenses.

Coinsurance

After you meet the annual applicable deductible, you and the Company share the remaining expenses through coinsurance.

Under the Out-of-Area Comprehensive Medical Plan, the company pays 80% of the reasonable and customary cost for covered expenses, and you are responsible for the remaining 20% of covered expenses, up to the annual out-of-pocket expense limit.

Out-Of-Pocket Limit

There is a limit to the share of medical expenses you have to pay during each calendar year. This expense amount is known as the out-of-pocket limit.

The deductible **does not** count toward the out-of-pocket limit. If you reach your out-of-pocket limit within a calendar year, your covered expenses will be paid at 100% for the remainder of that year and the next calendar year. If you do not reach your out-of-pocket limit, you must start accumulating expenses over again, beginning at $0 each January. However, mental health and chemical dependency charges and precertification penalties cannot be applied to your out-of-pocket limit.

Lifetime Maximum Benefit

The Plan provides an unlimited Lifetime Maximum Benefit for you and each covered member of your family.

Your Contributions

American Water Works pays the majority of your medical and dental benefits costs.

Your share of the cost (your contribution) of your benefits is paid each pay cycle, through convenient *pretax* payroll deductions. ***Pretax*** means that your contributions are withheld before federal (and in most cases, state and local) income and FICA taxes are withheld. This reduces your taxable income and the amount of tax you pay. As a result, the impact of your contribution on your take-home pay is substantially reduced. Please refer to page 16 for the contribution schedule.

Precertification

Precertification is an important feature of the Out-of-Area Comprehensive Medical Plan.

In order to receive the highest level of benefits available, you must contact Aetna at (800) **333-4432** or Member Services to precertify any hospital admissions and certain outpatient surgical procedures, treatments, and tests. The purpose of this process is to review the medical necessity of a procedure and to approve a reasonable length of stay.

What Procedures Must Be Precertified

Precertification is required for:

- All hospital admissions.
- Inpatient treatment for substance abuse and mental disorders.
- Certain outpatient surgeries, treatments, and tests. These include:
  - Allergy immunotherapy
  - Bunionectomy
  - Carpal tunnel surgery
  - Colonoscopy
  - Coronary angiography
  - CT scan – spine
  - Dilation and curettage (D&C)
  - Hemorrhoidectomy
  - Knee arthroscopy
  - Laparoscopy (pelvic)
  - MRI – knee

- MRI – spine
- Septorhinoplasty
- Tympanostomy tube
- Upper gastrointestinal endoscopy

Certification for Hospital Admissions

inpatient hospital confinements must be precertified to qualify for the highest level of benefits paid by the Plan. If precertification is not obtained, benefits will be reduced.

Hospital Expenses Incurred During the Confinement

If certification has been requested and denied, no benefits will be paid for Hospital Expenses incurred for room and board. Benefits for all other Hospital Expenses will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is not necessary, no benefits will be paid for Hospital Expenses incurred for room and board.

Other Hospital Expenses

Expenses, up to the Excluded Amount, will not be considered to be Covered Medical Expenses. Benefits for such expenses in excess of the Excluded Amount will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is necessary, Hospital Expenses, up to the Excluded Amount, will not be considered to be Covered Medical Expenses. Benefits for all other Hospital Expenses will be payable at the Payment Percentage.

Whether or not a day of confinement is certified, no benefit will be paid for expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan, except that, if certification has been given for a day of confinement, the exclusion of services and supplies because they are not necessary will not be applied to expenses for hospital room and board.

When to Request Precertification

If the admission is a non-urgent admission, you or your doctor must get the days certified by calling **(800) 333-4432** or Aetna Member Services at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an emergency or an urgent admission, you, the person's physician, or the hospital must get the days certified. This must be done:

- Before the start of a confinement as a full-time inpatient which requires an urgent admission, or
- Not later than 48 hours following the start of a confinement as a full-time inpatient which requires an emergency admission, unless it is not possible for the physician to request certification within that time. In that case, it must be done as soon as reasonably

possible. In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours

A "non-urgent admission" is one which is not an emergency admission or an urgent admission.

If, in the opinion of the person's physician, it is necessary for the person to be confined for a longer time than already certified, you, the physician, or the hospital may request that more days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the hospital. A copy will be sent to you and to the physician.

How to Request Precertification

To request precertification of an admission or procedure, just call (800) 333-4432 or Aeha Member Services, toll-free. at (800) 292-4366.

When you call, you will speak to a Nurse Consultant who will ask you:

- Your name and Social Security number,
- The relationship of the patient to you,
- What type of surgical procedure or test you need,
- The name and telephone number of your doctor, and
- When the procedure is scheduled.

The Nurse Consultant will review the medical necessity of the proposed inpatient admission, the proposed surgical procedures and treatments, or the proposed inpatient treatment for substance abuse and mental disorders. He or she will compare information about your case with generally accepted medical standards.

If, in accordance with such standards, the proposed inpatient admission or treatment is medically necessary, it will be certified by the Nurse Consultant. On the other hand, if other treatment is more appropriate, alternative treatment settings may be suggested.

There Is A Penalty If You Don't Precertify

If you do not call Aetna Member Services to precertify a hospital admission or any of the procedures or tests listed, you will be responsible for a separate $150 penalty charge, in addition to your deductible, before benefits are paid for covered services. This penalty charge will not be applied toward your deductible or your out-of-pocket limit.

If certification has been requested and denied, no benefits will be paid for Hospital Expenses incurred for room and board. Benefits for all other Hospital Expenses will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is not necessary, no benefits will be paid for Hospital Expenses incurred for room and board.

If Your Hospital Stay Is Longer Than Expected

If your hospital stay is longer than the approved period, you or your doctor must call **(800) 333-4432** or Aetna Member Services as soon as you are aware of the need to extend your length of stay. The Nurse Consultant can then work with your doctor to extend the certification of your hospital stay.

Expenses Covered by the Plan

Hospital Care

inpatient admissions must be precertified to qualify for the maximum benefit payable by the Plan.

Charges made by a hospital for providing room and board and other hospital services and supplies to a person who is confined as a full-time inpatient are covered by the Plan. Not included is any charge for daily room and board in a private room over the Semi-Private Room Limit.

Charges made by a hospital for hospital services and supplies given to a person who is an outpatient are also covered by the Plan.

Weekend Hospital Admissions

If an individual is confined as an inpatient in a hospital for non-emergency treatment and the confinement begins on a Friday, Saturday, or Sunday, charges made for room and board by the hospital for the following day of the confinement will be reduced by 50%. As used here, "non-emergency" means the treatment can be postponed without undue risk to the patient. The following will not be included as Covered Medical Expenses:

- The first Friday, Saturday, and Sunday of the confinement if it begins on a Friday.
- The first Saturday and Sunday of the confinement if it begins on a Saturday.
- The first Sunday of the confinement if it begins on a Sunday.

However, this limitation will not apply:

a To the first Sunday of any confinement that begins on a Friday, Saturday, or Sunday, unless the next following Monday is a legal holiday.

If a surgical procedure is performed on the day of or the day following the beginning of the confinement.

Convalescent Facility Care

Convalescent facility coverage is limited to 120 days per calendar year.

Charges made by a convalescent facility for the following services and supplies are covered if furnished to a person confined to convalesce from an illness or injury. The confinement must start during a "Convalescent Period."

- Room and Board. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any charge for daily room and board in a private room over the Private Room Limit.
- Use of special treatment rooms
- X-ray and lab work
- Physical, occupational, or speech therapy
- Oxygen and other gas therapy
- Other medical services usually given by a convalescent facility. This does not include private or special nursing, or physicians' services.
- Medical supplies

Benefits will be paid for up to the maximum number of days during any one Convalescent Period. This starts on the first day a person is confined in a convalescent facility if he or she:

- Was confined in a hospital for at least three days in a row, while covered under this Plan for treatment of an illness or injury,
- Is confined in the facility within 14 days after discharge from the hospital, and
- Is confined in the facility for services needed to convalesce from the condition that caused the hospital stay. These include skilled nursing and physical restorative services.

It ends when the person has not been confined in a hospital, convalescent facility, or other place giving nursing care for 90 days in a row.

The Plan does not cover charges made for treatment of:

- Drug addiction,
- Chronic brain syndrome
- Alcoholism
- Senility
- Mental retardation
- Any other mental disorder

Home Health Care

Home health care expenses are covered if:

- The charge is made by a home health care agency, and
- The care is given under a home health care plan, and
- The care is given to a person in his or her home.

Home health care visits are limited to 120 in a calendar year. Each visit by a nurse or therapist is one visit. Each visit of up to four hours by a home health aide is one visit.

Home health care expenses are charges for:

- Part-time or intermittent care by an R.N., or by an L.P.N. if an R.N. is not available.
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational, and speech therapy.

The following expenses are covered to the extent they would have been covered under this Plan if the person had been confined in a hospital or convalescent facility:

- Medical supplies, drugs, and medicines prescribed by a physician, and
- Lab services provided by or for a home health care agency.

The Plan does not cover home health care charges made for:

- Services or supplies that are not a part of the home health care plan.
- Services of a person who usually lives with you or is a member of your spouse's family.
- Services of a social worker
- Transportation

Pre-Operative Testing

Charges made by a hospital, surgery center, licensed diagnostic lab facility, or physician, on its own behalf, to test a person while an outpatient before scheduled surgery are covered if:

- The tests are related to the scheduled surgery,
- The tests are done within the seven days prior to the scheduled surgery,
- The person undergoes the scheduled surgery in a hospital or Surgery center; this does not apply if the tests show that surgery should not be done because of his/her physical condition,
- The charge for the surgery is a Covered Medical Expense under this Plan,
- The tests are done while the person is not confined as an inpatient in a hospital,
- The charges for the tests would have been covered if the person were confined as an inpatient in a hospital,

- The test results appear in the person's medical record kept by the hospital or surgery center where the surgery is to be done, and
- The tests are not repeated in or by the hospital or surgery center where the surgery is done.

If the person cancels the scheduled surgery, benefits are paid at the payment percentage that would have applied in the absence of this benefit. They are paid as any other expense, 80% after the deductible.

Birthing Center Care

This Plan pays for charges made:

- By a birthing center. Included are charges made, on its own behalf, for services and supplies fumished for:
  - prenatal care,
  - delivery of a child or children, and
  - postpartum care rendered within 24 hours after the delivery
- By an operating physician. Included are charges for the services shown below. The services must have been received in connection with the above services and supplies furnished by the birthing center:
  - performing an obstetrical procedure,
  - related pre- and postoperative care, and
  - administering an anesthetic
- Charges by any other physician for the administering of an anesthetic. This does not include a local anesthetic.

No benefit is paid for charges incurred:

- For the services of a physician who renders technical assistance to the operating physician.
- In connection with a pregnancy for which pregnancy related expenses are not included as a Covered Medical Expense.

Hospice Care

The Plan covers Hospice Care for an individual who is diagnosed as having six months or less to live.

Charges made for services furnished to a person for Hospice Care when given as a part of a Hospice Care Program are included as Covered Medical Expenses when made on its own behalf by a:

- Hospice facility
- Hospital
- Convalescent facility

The charges must be for room, board, and other services and supplies fumished to a person while a full-time inpatient for pain control or other acute and chronic symptom management. Any charge for daily room and board in a Private Room which exceeds the Private Room Limit is not included. The charge for any day of confinement in

excess of the Maximum Number of Days (90 day lifetime maximum) for all confinements for Hospice Care is also excluded.

In addition, the charges must be:

For services and supplies furnished to a person while not confined as a full-time inpatient.

- Part-time or intermittent nursing care by an R.N. or L.P.N. for up to eight hours in any one day.
- Medical social services under the direction of a physician. These include:
  - assessment of the person's social, emotional, and medical needs and the home and family situation.
  - identification of the community resources which are available to the person.
  - assisting the person to obtain those resources needed to meet the person's assessed needs.
  - psychological and dietary counseling.
  - consultation or case management services by a physician.
  - physical and occupational therapy.
  - part-time or intermittent home health aide services for up to eight hours in any one day. These consist mainly of caring for the person.
  - medical supplies, drugs, and medicines prescribed by a physician.
- Charges made by the providers below, but only if the provider is not an employee of a Hospice Care Agency and such agency retains responsibility for the care of the person:
  - a physician for consultant or case management services
  - a physical or occupational therapist
  - a Home Health Care Agency for:
    - physical or occupational therapy,
    - part-time or intermittent home health aide services for up to eight hours in any one day (consisting mainly of caring for the person),
    - medical supplies, drugs, and medicines prescribed by a physician,
    - psychological and dietary counseling.
- Outpatient hospice care is subject to a lifetime maximum of $5,000.

Not *included are charges made:*

- For bereavement counseling
- For funeral arrangements
- For pastoral counseling
- For financial or legal counseling. These include estate planning or the drafting of a will.
- For homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family, transportation, housecleaning, and maintenance of the house.
- For respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

Mouth, Jaws, and Teeth

The Medical Plan covers certain treatments of the mouth, jaws, and teeth only in the event of injury Treatment must be of, or related to, the teeth, mouth, jaws, jaw joints, or supporting tissues (these include bones, muscles. and nerves).

The following services and supplies furnished for the treatment of the mouth, jaws, jaw joints, teeth, and supporting tissues (including bones, muscles, and nerves) are Covered Medical Expenses and not part of the Dental Plan. For these expenses, "physician" includes a dentist.

- Surgery needed to treat a fracture, dislocation, or wound or to cut out teeth partly or completely impacted in the bone of the jaw. Covered surgery may cut out teeth that will not erupt through the gum, as well as other teeth that cannot be removed without cutting into bone.
- Also covered are surgeries that cut out the roots of a tooth without removing the entire tooth, as well as removing cysts, tumors, or other diseased tissues while cutting into the gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement, or repair of teeth. Covered surgery may also alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.
- Dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition natural teeth damaged, lost, or removed, and other body tissues of the mouth fractured or cut due to injury. The accident causing the injury must occur while the person is covered under the Medical Plan.

Any such teeth must have been free from decay or in good repair and firmly attached to the jaw bone at the time of the injury.

The treatment must be done in the calendar year of the accident or the next one.

If crowns (caps), dentures (false teeth), bridgework, or in-mouth appliances are installed due to such injury, Covered Medical Expenses include only charges for the following:

- the first denture or fixed bridgework to replace lost teeth,
- the first crown needed to repair each damaged tooth, and
- an in-mouth appliance used in the first course of orthodontic heatment after the injury.

The Medical Plan will cover certain expenses only in the event of injury. Charges for root canal therapy; routine tooth removal (which does not involve cutting of the bone); and in-mouth appliances, crowns, bridgework, dentures, tooth restorations, and any related fitting or adjustment services (whether or not their purpose is to relieve pain) are covered if they are required as the result of injury to the mouth, jaw, or teeth.

The Medical Plan does not cover charges to remove, repair, replace, restore, or reposition teeth which are lost or damaged in the course of biting or chewing. Charges to repair, replace, or restore fillings, crowns, dentures, or bridgework are not covered by the Medical Plan. Non-surgical periodontal treatment is excluded, as are charges for dental cleaning; in-mouth scaling, planing, or scraping; and myofunctional therapy (muscle training therapy to correct or control harmful habits).

Other Covered Medical Expenses

Other covered medical expenses include:

- Services of a physician.

  Charges made by an R.N. or L.P.N. or a nursing agency for skilled nursing care.

  - As used here, "skilled nursing care" means these services:
    - visiting nursing care by an R.N. or L.P.N. Visiting nursing care means a visit of not more than four hours for the purpose.
    - private duty nursing by an R.N. or L.P.N. if the person's condition requires skilled nursing services and visiting nursing care is not adequate.

  Not included as 'Skilled nursing care" is:

  - that part or all of any nursing care that does not require the education, training, and technical skills of an R.N. or L.P.N., such as transportation, meal preparation, charting of vital signs, and companionship activities;

- any private duty nursing care, given while the person is an inpatient in a hospital or other health care facility;
- care provided to help a person in the activities of daily life, such as bathing, feeding, personal grooming, dressing, getting in and out of a bed, chair, or toileting; or
- care provided solely for skilled observation, other than for a period of up to 4 hours per day for no more than 10 consecutive days following the occurrence of
- change in patient medication,
  - need for treatment of an emergency condition by a physician, or the onset of symptoms indicating the likely need for such treatment,
  - surgery, or
  - release from inpatient confinement; or
- any service provided solely to administer oral medicines, except where applicable law requires that such medicines be administered by an R.N. or L.P.N.

■ Drugs and medicines which by law need a physician's prescription and are dispensed by a non-preferred pharmacy.

■ Diagnostic lab work and X-rays.

a X-ray, radium, and radioactive isotope therapy

■ Anesthetics and oxygen.

■ Rental of durable medical or surgical equipment.

■ The purchase, repair, or replacement of durable medical and surgical equipment, and accessories needed to operate it. The initial purchase of such equipment and accessories is covered only if Aetna is shown that:

- long term use is planned, and
- the equipment cannot be rented, or
- it is likely to cost less to buy it than to rent it.

Replacement will be covered only if Aetna is shown that:

- it is needed because of a change in the person's physical condition, or
- it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.

Not included are charges for more than one item of equipment for the same or similar purpose.

■ "Durable Medical and Surgical Equipment" is equipment that is:

- made to withstand prolonged use,

- made for and mainly used in the treatment of a disease or injury,
- suited for use in the home,
- not normally of use to persons who do not have a disease or injury,
- not for use in altering air quality or temperature, and
- not for exercise or training.

- Artificial limbs and eyes (not including eye exams, eyeglasses, orthopedic shoes, or other devices to support the feet).

Professional ambulance or railroad service within the United States and Canada to transport a person from the place where he is injured or stricken by an illness to the first hospital or sanitarium where treatment is given.

Therapeutic injections of joints and tendons.

- Casts, splints, trusses, braces, crutches, and surgical dressings.

Pre-Existing Conditions

Pre-Existing Conditions do not apply under any Aetna Plan.

Confinement for Treatment of Alcoholism or Drug Abuse

Certain expenses for alcoholism or drug abuse treatment (coverage for employee and dependents) are Covered Medical Expenses, if the employee is a full-time inpatient in either a hospital or a treatment facility.

Hospital Confinement

Expenses for the following are covered:

- Treatment of the medical complications of alcoholism or drug abuse, such as cirrhosis of the liver, delirium tremens, or hepatitis.

- Effective treatment of alcoholism or drug abuse. This is covered only if there is not a separate treatment facility section.

Treatment Facility Confinement

Remember, for alcoholism and drug abuse. you must obtain precertification for an inpatient admission. If you fail to do so, benefits payable may be reduced.

Certain expenses for the effective treatment of alcoholism or drug abuse are covered. They are covered if they are incurred in the first 45 days of full-time confinement in a calendar year. The expenses covered are those for:

- Room and Board. Not covered is any charge for daily room and board in a private room over the Private Room Limit.
- Other necessary service and supplies.

This 45 days will be reduced by any days of hospital confinement for effective treatment of alcoholism or drug abuse that are covered above in the same calendar year. In addition, a separate Lifetime Maximum benefit of 90 days applies for effective treatment of alcoholism or drug abuse.

Mental Disorders

Remember. for mental and nervous disorders, you must obtain precertification for an inpatient admission. If you fad to do so, benefits payable may be reduced.

Expenses for the treatment of a mental disorder are Covered Medical Expenses to the extent shown below.

- If a person is a full-time inpatient in a hospital, these expenses are covered in the same way as those for any other disease.
- If a person is not a full-time inpatient in a hospital, treatment for mental disorders for outpatient care will be paid at 100% of the first $500.00 thereafter 50%, after you have reached the Medical Plan deductible.

Submitting Claims

You should file your claim(s) during the calendar year in which the service or treatment was provided.

AN claims must be filed within two years from the date of the incurred expense. Your claims must be in writing, and you must give proof of the nature and extent of the expense. You may obtain Medical Plan Benefits Request forms from your Human Resources representative.

How Your Benefits Are Paid

The Out-of-Area Comprehensive Medical Plan is an insured plan underwritten by Aetna.

Aetna pays your claims as soon as it receives the necessary written proof supporting your claim. In order to speed claims processing, Aetna will pay medical benefits directly to the provider unless you specify that you want the benefits paid to you. If you are a minor or otherwise legally unable to give a valid release, Aetna may make payment to any of your relatives whom it determines to be fairly entitled to the payment.

How to File a Medical Claim

Attach the original of each itemized bill to the Benefits Request form. Be sure to keep a copy of all bills and claim forms for your records. Rather than submitting individual medical bills, you may find it more convenienf to collect several bills and file them all at one time with your Benefits Request form.

Fast processing of your claim depends on complete, accurate information on your ***Benefits Request*** form. When filing a claim under the Out-of-Area Comprehensive Medical Plan, please remember to:

- Complete all applicable sections of your claim form. Any unanswered questions will cause delay in processing your claim;
- Be sure to include your Social Security number on all claims, including claims for your dependent(s). Also be sure to sign the form; and

  Attach the itemized bill to the form. An itemized bill must include the following information:

  - the patient's full name,
  - the patient's relationship to you,
  - the date service was provided,
  - the name of the health care professional providing service,
  - the provider's taxpayer identification number,
  - the type of service provided,
  - the nature of the illness or injury, and
  - the charges for the service or treatment (multiple expenses should be itemized).

If any of this information is missing, write it on the bill yourself and sign your name. Your health care provider should complete the provider/supplier section of the ***Benefits Request*** form if he or she has not given you an itemized statement.

If you have "other group" or Medicare coverage that pays benefits prior to American Water Works Plan, you will need to provide Aetna with a copy of the other carrier's Explanation of Benefits reflecting the benefits paid under the other coverage on the expenses being

submitted for payment under the Out-of-Area Comprehensive Medical Plan.

Once you have completed the ***Medical Plan Benefits Request*** form and attached the itemized bills, send everything to:

Aetna
P.O. Box 3929
Allentown, PA 18106-9861

If you have any questions about the status of your claim, call Aetna Member Services at **(800) 292-4366.**

Provisions That Apply to All Aetna Medical Plans

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General Exclusions Under All Aetna Plans

Coverage is not provided for the following charges:

- Those for services and supplies not necessary, as determined by Aetna, for the diagnosis, care, or treatment of the illness or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending physician or dentist.

  Those for care, treatment, services, or supplies that are not prescribed, recommended, and approved by the person's attending physician or dentist.

- Those for, or in connection with, services or supplies that are, as determined by Aetna, considered to he experimental or investigational. A drug, device, procedure, or treatment will be determined to be experimental or investigational:

  - if there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the illness or injury involved; or
  - if required by the FDA, approval has not been granted for marketing; or
  - if a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or
  - if the written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment or the written informed consent used by the treating facility studying the same drug, device, procedure, or treatment states that it is experimental , investigational, or for research purposes.

  However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with an illness, if Aetna determines that:

  - the illness can be expected to cause death within one year, in the absence of effective treatment; and
  - the care or treatment is effective for that illness or shows promise of being effective for that illness as demonstrated by scientific data. In making this determination Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of illness involved.

Also, this exclusion will not apply with respect to drugs that:

- have been granted approval as an investigational new drug with treatment status or
- have been granted approval as an investigational new drug with cancer treatment status

if Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the illness.

- Those for or related to services, treatment, education, testing, or training related to learning disabilities or developmental delays.

  Those for care furnished mainly to provide a surrounding free from exposure that can worsen the person's illness or injury.

- Those for, or related to, the following types of treatment:
  - primal therapy
  - rolfing
  - psychodrama
  - megavitamin therapy
  - bioenergetic therapy
  - vision perception training
  - carbon dioxide therapy
- Those for treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- Those for services of a resident physician or intern rendered in that capacity.
- Those to the extent they are not reasonable charges, as determined by Aetna.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- Those, as determined by Aetna, to be for custodial care.

  Those for services and supplies:
  - furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.
  - furnished, paid for, or for which benefits are provided or required under any law of a government. (This does not include a plan established by a government for its own employees or their dependents or Medicaid.)

- Those for or related to any eye surgery mainly to correct refractive errors.
- Those for education, special education, or job training, whether or not given in a facility that also provides medical or psychiatric treatment.
- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies that improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extent needed to:
  - improve the function of a part of the body that is not a tooth or structure that supports the teeth, or
  - is malformed as a result of:
    - a severe birth defect (this includes harelip or webbed fingers or toes), or
    - a direct result of surgery performed to treat an illness or injury; or
  - repair an injury that occurs while the person is covered under this Plan.

Surgery must be performed in the calendar year of the accident that causes the injury or in the next calendar year.

- Those that are for therapy or for supplies or for counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Those for or related to sex change surgery or to any treatment of gender identity disorders.
- Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures.
- Those for the reversal of a sterilization procedure.
- Those for routine physical exams, routine vision exams, routine hearing exams, routine dental exams, immunizations, or other preventive services and supplies.
- Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.
- Those for acupuncture therapy. Not excluded is acupuncture when it is:
  - performed by a physician, and
  - as a form of anesthesia in connection with surgery that is covered under this Plan.
- Those for or in connection with speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function

(the ability to express thoughts, speak words, and form sentences) as the result of an illness or injury.

Any exclusion above will not apply to the extent that:

- Coverage is specifically provided by name in this Summary Plan Description booklet, or
- Coverage of the charges is required under any law that applies to the coverage.

These excluded charges will not be used when calculating benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

Any charge for a service or supply furnished by a Preferred Care Provider in excess of such provider's Negotiated Charge for that service or supply will not be a covered expense under the Plan of benefits. This rule will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid. ***(This paragraph is not applicable to the Out-of-Area Comprehensive Medical Plan.)***

Coordination of Your Benefits With Other Plans, Not Including Medicare

If you have other group coverage, the benefits from those plans will be taken into account when you have a claim.

Today, in many situations, both husbands and wives work. Therefore, it is common for individual members of a family to be eligible for benefits under more than one group medical or dental plan. In such situations the benefits of the various plans are "coordinated" to determine how covered expense will be paid by your American Water Works Plan and the other plans. This may mean a reduction in benefits under this Plan. The combined benefits will not be more than the expenses recognized under these American Water Works Plans.

"Other plans" means:

- Any group medical or dental plan for which an employer pays all or part of the costs or makes payroll deductions,
- Any plan that yon purchase through a group such as AARP, or
- Any government program, coverage required or provided by any law, or vehicle insurance (uninsured/underinsured motorist and casualty/liability).

In a calendar year, your American Water Works Plan will pay:

- Its regular benefits in full, or

  A reduced amount of benefits calculated as follows:

  100% of "Allowable Expenses" incurred by the person for whose claim is made, less the benefits payable by the "other plans." (Some plans may provide benefits in the form of services rather than cash payments. If this is the case, the cash value will be used.)

"Allowable Expenses" means any necessary and reasonable health expense, part or all of which is covered under any of the plans covering the person for whom the claim is made. Not included is any expense in General Exclusions.

The difference between the cost of a private hospital room and the semi-private rate is not considered an Allowable Expense under the above definition, unless the patient's stay in a private hospital room is medically necessary, either in terms of generally accepted medical practice or as specifically defined in this Plan.

When benefits under the primary plan (the plan that pays its benefits first) are reduced because a covered person does not comply with the Plan provisions, the amount of the reduction will not be considered an Allowable Expense.

Examples of such provisions include those related to penalties resulting from the failure to comply with cost management provisions of the Plan.

When other coverage exists in addition to your American Water Works coverage, the following rules will be used to determine which medical or dental plan is primary and pays first, and which medical or dental plan is secondary and pays second:

- A plan with no rules for coordination with other benefits will pay its benefits before a plan which contains such rules.
- A plan that covers a person as an employee pays before the plan that covers the person as a dependent. However, there may be situations where the person is a Medicare beneficiary and has a working spouse. In such a situation,
  - The spouse's plan which covers the person as a dependent pays first,
  - Medicare pays second, and
  - The plan covering the person as an employee pays third.
- Except in the case of a dependent child whose parents are divorced or separated, the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which

covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

- If the other plan does not have the rule described in the above provision and, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

  In the case of a dependent child whose parents are divorced or separated:

  - If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order ofbenefit determination rules specified in the above provision will apply.
  - If there is a court decree which makes one parent financially responsible for the medical, dental, or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.
  - If there is not such a court decree:

    If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

    If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

- If the above rules do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first, except that the benefits of a plan which covers the person as a:

  - laid-off or retired employee, or
  - the dependent of such person,

  shall be determined **after** the benefits of any other plan which covers such person as:

  - an employee who is not laid-off or retired, or
  - a dependent of such person.

- If the other plan does not have a provision regarding laid-off or retired employees and, as a result, each plan determines its benefits after the other, then the previous paragraph will not apply.
- The benefits of a plan which covers the person under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.
- If the other plan does not have a provision regarding right of continuation pursuant to federal or state law, and as a result, each plan determines its benefits after the other, then the above paragraph will not apply.

Aetna bas the right to release or obtain any information and to make or recover any payment it considers necessary in order to administer this provision.

When this provision operates to reduce the total amount of benefits otherwise payable to you under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of your American Water Works Plan.

Automobile Personal Injury Protection (PIP)

If you are injured in an automobile accident and become eligible for benefits under the personal injury protection (PIP) provision of an automobile insurance policy, benefits under the American Water Works Medical Benefits Plan are payable after the automobile insurance policy benefits have been paid.

Subrogation

As a condition to payment of benefits under this Plan for expenses incurred by a covered person due to injury or illness for which a third party may be liable:

- The Plan shall, to the extent of benefits it has been paid, be subrogated to (has the right to pursue) all rights of recovery of covered persons against:
  - such third party; or
  - a person's insurance carrier in the event of a claim under the uninsured or underinsured auto coverage provision of an auto insurance policy.
- The Plan shall have the right to recover from the covered person amounts received by judgment, settlement, or otherwise from: such third party or his or her insurance camer; or any person or entity, which includes the auto insurance camer which provides the covered person's uninsured or underinsured auto insurance coverage.
- The covered person (or person authorized by law to represent the covered person if he or she is not legally capable) shall: execute and deliver any documents that are required; and do whatever else is necessary to secure such rights.

When an Active Employee Is Eligible for Coverage Under Medicare

If an active employee or covered dependent is eligible for Medicare, American Water Works Medical Plan will be primary and Medicare will coordinate with it.

Coverage under American Water Works Medical Plan will be changed for any person while eligible for Medicare. A person is "eligible for Medicare" if he or she:

- Is covered under it,
- Is not covered under it because of:
  - having refused it,

- having dropped it, or
- having failed to make proper request for it

If an active employee or eligible dependent is covered under an American Water Works Plan and is eligible for Medicare:

- All health expenses covered under this Plan will be reduced by any Medicare benefits that are available for those expenses. This will be done before the health benefits of this Plan are calculated.
- Charges used to satisfy a person's Medicare Part B deductible will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.

  Medicare benefits will be taken into account for any active employee or covered dependent while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.

Any rule for coordinating "other plan" benefits with those under this Plan will be applied after American Water Works benefits have been calculated under the above

Effect of Prior Coverage

If the coverage of any person under any part of this Plan replaces any prior coverage of the person, the rules below apply to that part.

"Prior coverage" is any plan of group health or accident coverage that has been replaced by coverage under part or all of this Plan. It must have been sponsored by your Employer. The replacement can be complete or in part for the Eligible Class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this Plan.

When Coverage Is Terminated

Coverage under any section of this Plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this Plan.

Coverage under either Plan terminates when the first of these events happens:

- The day your employment ends
- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution

Under certain circumstances, American Water Works may continue your coverage when you are not actively at work:

- If you are not at work due to illness or injury:
  - American Water Works medical coverage will be continued for the length of your disability payments, not to exceed 24 months from the date you are disabled.
  - If your employment terminates and you or your dependents are totally disabled at the time of termination, coverage will continue for up to 12 months for medical expenses related to the disabling condition.

A dependent's coverage will terminate at the first to occur of

- The termination of all dependents' coverage under the group contract.
- When a dependent becomes covered as an employee.
- When such person is no longer an Eligible Dependent.
- When your coverage terminates.

Coverage for Handicapped Dependent Children

Health Expense Coverage for your fully handicapped child may be continued past the maximum age for a dependent child if the child has not been issued a personal medical conversion policy.

Health Expense Coverage for your fully handicapped child may be continued past the maximum age for a dependent child if the child has not been issued a personal medical conversion policy.

Your child is fully handicapped if:

- He or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children, and
- He or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to Aetna no later than 31 days after the date your child reaches the maximum age of 19, or up to age 23 if attending school full-time.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proofthat the handicap continues
- Failure to have any required exam.
- Termination of Dependent Coverage for your child for any reason other than reaching the maximum age.

Aetna will have the right to require proof of the continuation of the handicap. Aetna also has the right to examine your child, at its own expense, as often as needed while the handicap continues. An exam will not be required more often than once each year after two years from the date your child reaches the maximum age.

Special Rules That Apply to an Adopted Child

Medical (or dental) coverage for an adopted child will become effective on the date the child is placed with you for adoption, if you make a written request for coverage within 31 days of his or her placement with your family. If the request is not made within 31 days, coverage for the child will be subject to all the terms of this Plan and

will only become effective if evidence of his or her good health. acceptable to Aetna, is provided.

Any provision of this Plan which:

a Requires evidence of good health which is acceptable to Aetna for coverage to become effective,

a Delays coverage due to a confinement,

will not affect the initial health coverage for a child who meets the definition of dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

Such placement takes effect after the date your coverage becomes effective, and

a You make written request for coverage for the child within 31 days of the date the child is placed with you for adoption.

Qualified Medical Child Support Orders (QMCSOs)

A "Qualified Medicai Child Support Order" (QMCSO) is an order by a court directing an employer to extend health plan participation to an employee's child who might not otherwise be a participant in the Plan..

QMCSOs are usually issued for children who reside with a former spouse. A QMCSO designates the affected child as an "alternate recipient."

American Water Works must treat an alternate recipient as an eligible dependent and must deduct any applicable contributions from the employee's pay. A QMCSO also requires the claim administrator to issue claim payments directly to the health care provider, the alternate recipient, or his or her legal representative. The child may designate a custodial parent or guardian to receive claim payments on his or her behalf. American Water Works is required to furnish an alternate recipient or his or her legal representative a copy of the Summary Plan Description.

If American Water Works receives a QMCSO affecting one of your children, you and your child will be notified Once American Water Works has determined thaf the medical child support order is qualified, you and your child will be advised. American Water Works will enroll the child and instruct Aetna to make all claim payments to either the health care provider, the alternate recipient, or his or her legal representative.

To be "qualified," a medical child support order must:

- Be issued by a court of competent jurisdiction,
- Include the name and last mailing address of both the employee and the affected child,
- Identify the health benefit plan subject to the order, and also the applicable time period,
- Provide a reasonable description of the type of benefits that must be provided for the child, and
- Not impose any benefits requirements that do not apply to other Plan participants.

If a child meets the definition of an eligible dependent and you are required to provide health care benefits for that child as the result of a QMCSO, his or her initial participation in an American Water Works Medical Plan will not be affected by any provision that:

- Requires evidence of good health as a condition of participation,
- Delays participation due to a confinement, or
- Limits participation due to a pre-existing condition.

However, for this special rule to apply, the QMCSO must be made on or after the date your own participation becomes effective. Coverage for the child will become effective on the date of such court order. If request is not made within 31 days, coverage for the child will be subject to all of the terms of this Plan and will become effective only if evidence of his or her good health, acceptable to Aetna, is given to Aetna.

If you are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

Adjustment Rule

if, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted. Any increase is subject to any active work rule or non-confinement requirements. Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised Plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

Conversion to a Personal Policy if Your Employment or Your COBRA Continuation Ends

If your medical coverage ceases, under the Managed Choice, HMO Elect Choice. or the Out-of-Area Comprehensive Medical Plan, you may be able to convert your group coverage to a personal medical policy underwritten by Aetna.

If your medical coverage ceases, under the Managed Choice, HMO Elect Choice, or the Out-of-Area Comprehensive Medical Plan, you may be able to convert your group coverage to apersonal medical policy underwritten by Aetna. No evidence of insurability is required. You and your family members may convert when all coverage ceases because your employment or COBRA continuation ceases or you cease to be in an eligible class. You may not convert if American Water Works discontinues these Plans.

The personal policy may cover:

- You only, or

  You and all of your family members who are covered under this Plan when your coverage ceases, or
- If you die before you retire, all your family members, or your spouse only, who are covered under either Plan when your coverage ceases.

Also, if your own coverage continues, your dependents can apply if they cease to be a dependent as defined in this Plan.

You may convert when you become a retired employee. However, if you elect to participate in American Water Works Retiree Medical Plan, this conversion privilege will not again be available to you.

The personal policy must be applied for within 31 days after coverage ceases or would otherwise cease without a provision to continue coverage for retired employees. The 31 days start on the date coverage actually ceases, even if the person is still eligible for benefits because the person is totally disabled.

Aetna will insure and administer the converted personal policy and may decline to issue the personal policy if:

- It is applied for in a jurisdiction in which Aetna cannot issue or deliver the policy.
- On the date of conversion, a person is covered, eligible, or has benefits available under one of the following:
  - any other hospital or surgical expense insurance policy,
  - any hospital service or medical expense indemnity corporation subscriber contract,
  - any other group contract,

- any statute, welfare plan, or program,

and which, with the converted policy, would result in overinsurance or match benefits.

You do not have the right to convert if you have been covered under this Plan for less than three months. Also, no person has the right to convert if:

- He or she has used up the maximum benefit, or
- He or she becomes eligible for any other Medical Expense Coverage under this Plan.

The personal policy, and its terms, will be of a type for group conversion purposes:

- As required by law or regulation, or
- As then offered by Aetna according to American Water Works conversion plan.

It will not provide coverage which is the same as coverage under this Plan. The level of coverage may be lower and an overall Lifetime Maximum Benefit will apply.

The personal policy may contain either or both:

- A statement that benefits under it will be cut back by any like benefits payable under this Plan after your coverage ceases.
- A statement that Aetna may ask for data about your coverage under any other plan. This may be asked for on any premium due date of the personal policy. If you do not give the data, expenses covered under the personal policy may be reduced by expenses which are covered or provided under those plans.
- The personal policy will state that Aetna has the right to refuse renewal under some conditions. These will be shown in that policy.

If you or your dependent want to convert, you can obtain a ***Notice of Conversion Privilege and Request*** form from your Human Resources representative, and send the completed form to the address shown on the form.

If a person is eligible to convert, information will be sent about the personal policy for which he or she may apply.

The first premium for the personal policy must be paid at the time the person applies for that policy. The premium due will be Aetna's normal rate for the person's class and age, and the form and amount of coverage.

The personal policy will take effect on the day after coverage terminates under American Water Works Plan.

Healthy Outlook Program

Aetna's Healthy Outlook Program provides educational materials and. in some cases, individualized case management for members, with an emphasis on health education and behavior modification for modifiable risks. Members are encouraged to work closely with their physician(s) to remain personally involved in their care. Associates with one of the conditions listed below may be identified as eligible for program participation. For additional information or to take part in this program call Aetna at (877) **526-9372.**

- asthma;
- congestive heart failure;
- coronary artery disease
- diabetes; and
- low back pain

A "participant" in this program is a covered person:

- who has identified himself or herself; or
- who has been identified by;

his or her attending physician or other health care provider; or

Aetna; or

his or her Employer; and

- who is approved by Aetna as a participant.

Any visit or day calendar year maximum, or visit or day lifetime maximum under this Plan will not be reduced. However, any dollar calendar year maximum or dollar lifetime maximum under this Plan will be reduced. Any applicable deductible will be waived.

The Prescription Drug Benefit Program

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The Prescription Drug Benefit Program

The Prescription Drug Benefit program is administered by Aetna. The program offers you two ways to receive medications – at a retail pharmacy or by mail-order.

- The Aetna Prescription Management (APM) Program. For your short-term and immediate prescription drug needs, you may use local participating pharmacies that have agreed to charge discounted prices.
- The Mail Order Drug Program. For medications that you use on an extended or regular basis, you may purchase up to a 90-day supply through Express Scripts. They will be delivered to you via mail or parcel delivery.

Coverage under the Prescription Drug Program ends when your American Water Works Medical Plan terminates.

What You Pay For Prescription Drugs

Description	Aetna Pharmacy Program	Mail Order Program
Prescription Need	Short-term / immediate	Long-term / ongoing
Cost to You	10% coinsurance (generic) 20% coinsurance (name-brand)	$ 5 (generic) $15 (name-brand)
Maximum Supply per Prescription	34-day supply or 100 unit doses	90-day supply
Claim Forms (Participating Pharmacy)	None	None
Claim Forms (Non-Participating Pharmacy)	Yes (through Direct Reimbursement Request)	None
Toll-Free Customer Service	Aetna Member Services **(800) 292-4366**	Express Scripts (877) 849-5521

Important Note: Coinsurance (20% and 10%) and copayments ($5 and $15) may not be applied to Medical or Dental Plan deductibles or maximums. In addition, certain controlled substances and other prescription medications may be subject to dispensing limitations and to the professional judgment of the pharmacist.

Covered Drugs

The Prescription Drug Program covers dmg that require a physician's written prescription and are medically necessary for the treatment of illness or injury.

- Covered drugs include, but are not limited to:
- Federal legend dmgs,
- State restricted drugs,
- Compounded medications,
- Injectable drugs, including insulin, needles, and syringes, and
- Oral contraceptives

How to Use the Aetna Pharmacy Management Program (APM)

Although you may use any pharmacy you wish, if you use a pharmacy that participates in the APM network, you will receive discounted prices, and you will not need to complete a claim form. When you enroll in the Managed Choice Plan, the HMO Elect Choice or the Out-of-Area Comprehensive Plan, you will receive a prescription ID card and a directory listing participating pharmacies in your area.

Using a Participating Pharmacy

Simply present your ID card and pay 20% (brand names) or 10% (generic) of the discounted prescription cost for a 34-day supply of medication. The Prescription Drug Plan pays 80% or 90%, respectively, of the discounted cost. There is no deductible to meet. Use your ID card when you need medication immediately.

When you use a participating pharmacy, you'll have no claim forms to complete and submit, and no waiting for reimbursement.

Using a Non-Participating Pharmacy

When you have a prescription filled at a pharmacy that does not participate in the APM network, you must pay the regular charge. Then, you must submit a claim form to Aetna at the address printed on the back of the Prescription Benefits claim form.

The Plan will pay 80% or 90% of the retail (non-discounted) cost of your prescription. Your reimbursement should amve about two weeks after you mail the claim form.

How the Mail Order Drug Program Works

The Mail Order Drug Program is designed to save you money on medications that you use on an extended or regular basis. The program allows you to receive up to a 90-day supply of a name-brand medication for $15 and generic medications for $5 per prescription.

Express Scripts administers the program. They maintain state-of-the-art facilities throughout the country that are capable of dispensing thousands of prescriptions each day.

Mail Order Drugs

The mail-order feature provided gives you the convenience of purchasing maintenance prescriptions by mail. Maintenance drugs are those that are used on an ongoing basis.

How to Obtain Mail Order Drugs

To use the Mail Order Drug Program, simply follow these easy steps:

- Complete Section 1 of the Express Scripts mail order form that is available from your Human Resources representative.

  Return the form, along with your prescriptions and the appropriate copayment to the Mail Order Drug Program administrator. The address is on the order form.
- Your medications will be sent via mail or parcel delivery in about two weeks, along with instructions for future refills.

Prescription Charges Not Covered

- The following drugs and supplies are not covered under the Prescription Drug Benefit Program.
  - Bandages
  - Braces
  - Cosmetics
  - Dietary supplements
  - Drugs intended for use in a physician's office or other setting that is not the participant's home
  - Certain experimental or investigational drugs
  - Fertility drugs
  - Health and beauty aids
  - Heat lamps
  - Non-legend drugs
  - Norplant
  - Prescriptions that a participant is entitled to receive without charge under any Worker's Compensation or municipal, state, or federal program.
  - Retin-A

    Splints and artificial appliances
  - Appetite suppressants that are *not* medically necessary
  - Any prescription medication that is also available over the counter
  - Devices and equipment
  - Injectable drugs (other than insulin)

In addition, certain controlled substances and other prescription medications may be subject to dispensing limitations and to the professional judgment of the pharmacist.

Termination of Coverage

Your prescription drug coverage ends when your Medical Plan terminates.

The Dental Plan

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An Overview Of the Plan

To help you take good care of your teeth American Water Works Dental Plan covers preventive, restorative, major, and orthodontic dental services.

Your dental health is an important aspect of your overall health and well-being. All employees and their dependents who enroll in either of American Water Works Medical Plans are also enrolled in the Dental Plan. This valuable benefit is self-insured by American Water Works. The provisions of the Plan will remain effective only while you are covered under the group contract.

The Plan pays benefits for charges for dental services and supplies incurred for treatment of a dental disease or injury. These benefits apply separately to each covered person.

The PPO dental plan offers in and out-of-network benefits.

Dental Plan Summary Chart

The following chart provides a summary of your dental benefit levels and coverages.

Dental Benefits	
Deductibles • Individual • Family	$ 50 annual $100 annual
Preventive Care (Type **A** Expenses)	100% (no deductible)
Restorative and Major Services (Type B Expenses)	80% after deductible
Calendar Year Maximum	$1,000
Orthodontia (Type C Expenses)	50% after deductible ($1,500 lifetime maximum)

Covered Dental Expenses

Expenses that exceed the necessary and appropriate level, as determined by Aetna, will not be covered by the Plan

The Plan pays a benefit for Covered Dental Expenses equal to the Payment Percentage:

- 100% of Preventive (Type A) expenses.
- 80% of Restorative and Major Services (Type B) expenses.
- 50% of Orthodontia (Type C) expenses up to a lifetime maximum of $1,500.
- Only certain dental expenses are covered. These are the dentists' charges for the services and supplies listed below which, for the condition being treated, are:
- Necessary,
- Customarily used nationwide, and
- Deemed by the profession to be appropriate. They must meet broadly accepted national standards of dental practice.

Type A Expenses – Preventive Services

- Oral exams once every six months. This includes prophylaxis, scaling, and cleaning of teeth.
- X-rays for diagnosis. Also other X-rays not to exceed one full mouth series in a 36-month period and one set of bitewings in a 6-month period.

Type B Expenses – Restorative and Major Services

Topical application of sodium or stannous fluoride for persons under 15 years of age.

- Space maintainers
- Non-surgical extractions
- Fillings.
- General anesthetics given in connection with covered dental services.
- Non-surgical treatment of diseased periodontal structures.
- Non-surgical endodontic treatment. This includes root canal therapy.
- Injection of antibiotic drugs.

Repair or recementing of crowns, inlays, bridgework, or dentures

- Relining of dentures.

First installation of removable dentures to replace one or more natural teeth extracted while the person is covered. This includes adjustments for the 6-month period following the date they were installed.

Replacement of an existing removable denture or fixed bridgework by a new denture, or the adding of teeth to a partial removable denture. Note: the "Prosthesis Replacement Rule" below must be met.

- Inlays, gold fillings, or crowns. This includes precision attachments for dentures.

First installation of fixed bridgework to replace one or more natural teeth extracted while the person is covered. This includes inlays and crowns as abutments.

- Replacement of an existing removable denture or fixed bridgework by new fixed bridgework, or the adding of teeth to existing fixed bridgework. Note: the "Prosthesis Replacement Rule" below must be met.

Type C Expenses – Orthodontic Treatment

A dentist's charges for services and supplies for Orthodontic Treatment are included as Covered Dental Expenses. In addition to all other terms of this dental benefit:

- The benefit rate will be the Payment Percentage for Orthodontic Treatment.
- Benefits will not exceed the Orthodontic Maximum for all expenses incurred by a family member in his or her lifetime. (It applies even if there is a break in coverage.)

For active employees who opt out of the Medical Plan, dental benefits may be purchased at the following cost:

Monthly Cost for Dental Coverage		
Calendar Year	**Single**	**Family**
2002	$ 6.00	$10.50
2003	$ 7.00	$12.50
2004	$ 8.00	$15.00
2005	$10.00	$18.00

Advance Claim Review

You should request an Advance Claim Review of any dentalprogram that will cost $150 or more. The review will tell you and your dentist what the Plan will cover and how much you must pay out of your own pocket.

Before starting a course of treatment for which dentists' charges are expected to be $150 or more, details of the proposed course of treatment and charges to be made should be filed in acceptable form with Aetna. Forms are available from your Human Resources representative. Aetna will then estimate the benefits. You and the dentist will be notified of the estimated coverage before treatment starts.

Some services may be given before an Advance Claim Review is made (emergency treatments and oral exams, including prophylaxis and X-rays).

A course of treatment is a planned program of one or more services or supplies to treat a dental condition. The condition must be diagnosed by the attending dentist as a result of an oral exam. The treatment may be given by one or more dentists. The course of treatment starts on the date a dentist first gives a service to correct or treat such dental condition.

Note: As a part of the Advance Claim Review and as part of proof of any claim:

- Aetna has the right to require an oral exam of the person at its own expense.
- You must give Aetna all diagnostic and evaluative material which it may require. These include: X-rays, models, charts, and written reports.

The benefits for a course of treatment may be for a lesser amount than would otherwise be paid if an Advance Claim Review is not made or if any required verifying material is not furnished. In this event, benefits will be reduced by the amount of Covered Dental Expenses that Aetna cannot verify.

Alternate Treatment

If alternate services or supplies may be used to treat a dental condition, Covered Dental Expenses will be limited to those services and supplies which:

- Are customarily used nationwide for treatment, and

Are deemed by the profession to be appropriate for treatment. They must meet broadly accepted national standards of dental practice. The person's total current oral condition will be taken into account.

The Limitations section has some examples of how this works. Please refer to page 142 for more information.

Prosthesis Replacement Rule

Certain replacements or additions to existing dentures or bridgework will be covered under this Plan. But proof satisfactory to Aetna must be given that:

- The replacement or addition of teeth is required to replace teeth extracted after the present denture or bridgework was installed. The person must have been covered when the tooth was extracted.

  The present denture or bridgework cannot be made serviceable. Also, it must be at least five years old.

- The present denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered and cannot be made permanent. Replacement by a permanent denture is needed. It takes place within 12 months from the date the immediate temporary one was first installed.

Explanation of Some Important Plan Provisions

Calendar Year Deductible

This is the amount of Covered Dental Expenses you pay each calendar year before benefits are payable. There is a separate Calendar Year Deductible for each person.

Family Deductible Limit

This is a valuable feature of the Plan. It represents the limit of Covered Dental Expenses that must be paid by persons in your family

before the Plan begins to pay benefits. When such expenses exceed the Family Deductible Limit, the Plan then pays benefits at 80 percent of the excess.

Coinsurance

Once the calendar year deductible has been met, you and the Plan share the cost of most dental services through the coinsurance. Coinsurance is the amount that you must pay out of your own pocket for covered services.

Calendar Year Maximum Benefit

This Plan has a Calendar Year Maximum Benefit. That is the most that is payable for all dental expenses incurred by a person in a calendar year. It applies even if there is a break in coverage.

Coordination of Benefits

Today, in many situations, both husbands and wives work. Therefore, it is common for individual members of a family to be eligible for benefits under more than one group medical or dental plan. In such situations the benefits of the various plans are "coordinated" to determine how covered expense will be paid by your American Water Works Plan and the other plans. This may mean a reduction in benefits under this Plan. The combined benefits will not be more than the expenses recognized under these American Water Works Plans.

in a calendar year, your American Water Works Plan will pay:

- Its regular benefits in full, or
- A reduced amount of benefits calculated as 100% of "Allowable Expenses" incurred by the person for whom a claim is made, less the benefits payable by the "other plans." (Some plans may provide benefits in the form of services rather than cash payments. If this is the case, the cash value will be used.)

Limitations

Covered services and supplies must meet broadly accepted standards of dental practice. When your dentist uses an alternate method of treatment, the benefits paid by American Water Works Plan will be limited.

When the Alternate Treatment part of this Plan applies, benefits will be limited. Some examples of how this works follow.

Restorative and Reconstructive Services

- Gold, Baked Porcelain, Crowns, and Jackets

  Covered Dental Expenses will be limited to the charges for the procedure using amalgam or like material, if it would restore a tooth. This limit applies even if you and the dentist choose some other type of restoration.

  Reconstruction

  Covered Dental Expenses will be limited to the charges for the procedure needed to eliminate oral disease and replace missing teeth. Appliances or restorations needed to increase vertical

dimension or restore the occlusion are deemed to be optional They are not covered.

Prosthodontic Services

- Partial dentures

  Covered Dental Expenses will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. This limit applies even if you and the dentist choose a more elaborate or precision appliance.

- Complete dentures

  Covered Dental Expenses will be limited to the charges for a standard procedure. This limit applies even if you and the dentist choose personalized or specialized treatment.

Replacement **of** Existing Dentures

This will be covered only if the existing denture cannot be used or repaired. If it can be used or repaired, Covered Dental Expenses will be limited to the charges for the services needed to make the denture usable. The following exclusions apply.

Exclusions

Covered Dental Expenses do not include, and no benefits are payable for:

Any dental services and supplies which are covered in whole or in part under any other part of this Plan, or under any other plan of group benefits provided by American Water Works.

- Treatment by someone other than a licensed dentist. But the Plan will cover some treatments by a licensed dental hygienist that are supervised by a dentist. These are scaling of teeth, cleaning of teeth, and topical application of fluoride.
- Services or supplies that are cosmetic in nature. This includes charges for personalization or characterization of dentures.
- The replacement of a prosthetic device that is lost, missing, or stolen.
- Any services or supplies which are for orthodontic treatment, except as specifically provided.
- Services or supplies to increase vertical dimension. These are dentures, crowns, inlays and onlays, bridgework, or any other appliance or service.
- Sealants

Termination of Coverage

The Dental Plan terminates when the Medical Plan terminates.

Benefits After Termination of Coverage

if your dental coverage ends while you are not totaliy disabled, charges for dentures, fixed bridgework, and crowns may be covered for a period of 60 days following the date coverage terminated if they were ordered before that date.

Expenses incurred for the following after the person's coverage ceases under this benefit section will be deemed to be incurred when ordered:

- Dentures
- Fixed bridgework.
- Crowns.

This applies only if the item is finally installed or delivered no more than 60 days after coverage ends.

"Ordered means:

- Impressions have been taken from which the dentures, crowns, or fixed bridgework will be made, and
- As to fixed bridgework and crowns, the teeth must have been fully prepared if they will serve as retainers or support or if they are being restored.

General Exclusions

Coverage is not provided for the following charges:

- Those for services and supplies not necessary, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending physician or dentist.

Those for care, treatment, services, or supplies that are not prescribed, recommended, and approved by the person's attending physician or dentist.

- Those for, or in connection with, services or supplies that are, as determined by Aetna, to be experimental or investigational. A dmg, device, procedure, or treatment will be determined to be experimental or investigational if:
    - there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved,
    - as required by the FDA, approval has not been granted for marketing,
    - a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes, or
    - the written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.
- Those for services of a resident physician, dentist, or intern rendered in that capacity.
- Those to the extent they are not reasonable charges, as determined by Aetna.

Those that are made only because there is health coverage.

Those that a covered person is not legally obliged to pay.

- Those for services and supplies:
    - furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.
    - furnished, paid for, or for which benefits are provided or required under any law of a government. (This does not include a plan established by a government for its own employees or their dependents or Medicaid.) **An** example is benefits provided, to the extent required by law, under "no-fault" auto insurance law.

- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extent needed to repair an injury which occurs while the person is covered under this Plan. Surgery must be performed
- in the calendar year of the accident which causes the injury, or in the next calendar year.
- Those for routine dental exams or other preventive services and supplies
- Those for acupuncture therapy. Not excluded is acupuncture when it is performed by a physician as a form of anesthesia in connection with surgery that is covered under this Plan.
- Those for sealants

Any exclusion above will not apply to the extent that coverage is specifically provided by name or coverage of the charges is required under any law that applies to the coverage. These excluded charges will not be used when calculating benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

Submitting Claims

You should file your claim(s) during the calendaryear in which the service or freafmenf was provided.

All claims must be filed within two years from the date of the incurred expense. Your claims must be in writing, and you must give proof of the nature and extent of the expense. You may obtain Dental Benefits Request forms from your Human Resources representative.

How Your Benefits Are Paid

The Denial Plan is underwritten and administered by Aetna. Your claims will be paid as soon as Aetna receives the necessary written proof supporting your claim. In order to speed the claims processing, Aetna will pay dental benefits to you unless you specify that you want the benefits paid to the provider.

How to File a Dental Claim

Attach the original of each itemized bill to the Dentist's Statement form. Be sure to keep a copy of all bills and claim forms for your records. Rather than submitting individual dental bills, you may find it more convenient to collect several bills and file them with your Dentist's Statement form at one time.

Fast processing of your claim depends on complete, accurate information on your Dentist's ***Statement*** form. When filing a claim under the Dental Plan, please remember to:

- Complete all items under applicable sections of your claim form. Any unanswered questions will cause delay in processing your claim;
- Be sure to include your Social Security number on all claims, including claims for your dependent(s). Also be sure to sign the form; and
- Attach the itemized bill to the form. An itemized bill must contain the following information:
    - the patient's full name,
    - the patient's relationship to you,
    - the date service was provided,
    - the name of the Dentist or other licensed health care professional providing service,
    - the provider's taxpayer identification number,
    - the type of service provided,
    - the nature of the condition being treated, and
    - the charges for the service or treatment (multiple expenses should be itemized).

If any of this information is missing, write it on the bill yourself and sign your name. Your dental provider should complete the provider section of the Benefits Request form if he or she has not given you an itemized statement.

If you have "other group" coverage that pays benefits prior to the Plan, you will need to provide Aetna with a copy of the other carrier's Explanation of Benefits statement reflecting the benefits paid under the other coverage on the expenses being submitted for payment under the Plan.

Once you have completed the claim form and attached the itemized bill(s) send everything to:

Aetna
P.O. **Box 3929**
Allentown, PA **18106-9861**

If you have any questions about the status of your claim, call Aetna Member Services at **(800) 292-4366.**

Flexible Spending Accounts

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The Health Care Spending Account 151
The Dependent Care Spending Account 159

Flexible Spending Accounts

Participation in the Health Care Spending Account and the Dependent Care Spending Account allows you to reduce your taxable income by paying for certain expenses with pretax dollars.

American Water Works recognizes that the high costs of health and dependent care can at times be overwhelming. To help you meet these expenses in the most cost-efficient manner, the Company offers two programs which, allow you to use your own pretax dollars to pay for qualifying health care and dependent care expenses.

Both programs provide for the establishment of spending accounts, to which you can make voluntary contributions on a pretax basis. Reimbursements are then made to you from these accounts to cover the cost of your qualifying medical and dependent care expenses.

Aetna administers the Flexible Spending Accounts on behalf of American Water Works.

The Health Care Spending **Account** reimburses you, tax-free, for most health-related expenses (including medical and dental) that are not reimbursable through any health benefit plans for yourself or your eligible dependents.

The Dependent Care Spending **Account** reimburses you, tax-free, for most dependent day care expenses for your qualifying dependents.

Your contributions to the Health Care and/or Dependent Care Spending Accounts, as well as the reimbursements that you receive from them, are not subject to federal income tax or Social Security taxes, and in most cases, state income tax, although the contributions may be subject to state and local taxes, depending upon where you live.

The Health Care Spending Account

You can use your Health Care Spending Account to pay for medical, dental, vision, and hearing care expenses that are not otherwise covered by any health care plan.

The Health Care Spending Account allows you to contribute money on a pretax basis to an account set up for you. If you (or your eligible dependents) incur qualifying health care expenses, which are not covered, or are only partially covered, by insurance or any other source, you will be reimbursed through the spending account for these expenses. Because your contributions to the spending account are not subject to federal tax, using the spending account allows you to pay for qualifying medical expenses while at the same time reducing your taxable income.

Here is an example of the potential savings with a Health Care Spending Account:

	With Account	Without Account
Annual Family Income	$40,000	$40,000
Pre-Tax Contributions to Account	$500	None
Taxable Income	$39,500	$40,000
Federal Income Tax	$3,585	$3,660
Social Security Tax	$3,022	$3,060
After-Tax Health Care Expenses	None	$500
Net Spendable Income	$32,893	$32,780
Tax Savings	**$113**	**$0**

Eligibility

To participate in the Health Care Spending Account, you must complete and submit an enrollment form within the 31-day enrollment period. If a signed form is not received within this period, American Water Works will assume that you have decided not to participate in the Plan, and you will not be eligible to participate until the following Plan Year.

All regular full-time employees are eligible to participate in the spending accounts at the same time you become eligible to participate in the Medical, Dental, and Prescription Drug Plans. You may enroll by completing and signing the Flexible Spending Account section on your Enrollment Form. If you are newly hired, you ***must*** enroll and make your contribution election within the 31-day enrollment period. You will have the opportunity to change your elections in the fall of every year, effective for the upcoming plan year. You are generally not permitted to make changes to your election amount during the Plan Year.

Eligible Dependents

Health Care expenses incurred by your eligible dependents can be reimbursed if the expenses are not covered by any medical, dental, or prescription drug plan.

In addition to your own expenses, you can also be reimbursed from the Health Care Spending Account for qualifying expenses incurred by an eligible dependent. In general, an eligible dependent is your spouse or any person whom you could claim as a dependent on your federal income tax return. If you are divorced, your children are eligible dependents only if they receive more than half of their support from you.

A special rule applies if your dependent (other than your spouse) is employed. He or she can be considered an eligible dependent only if his or her annual gross income is less than $2,000. However, a dependent child may earn more than $2,000 per year and still be eligible if he or she is not older than age 19 at the end of the Plan Year, or not older than age 23 and a full-time student during each of five calendar months of the year. You should consult your own tax advisor to determine whether your child is eligible to be your dependent.

How the Account Works

It is important to remember that the spending account does not replace your medical benefits. The spending account is a separate plan that reimburses you for qualifying expenses that are not covered, or only partially covered, by your Medical or Dental Plan or by any other source.

Assume that you are enrolled in one of American Water Works Medical Plans. You estimate that you will have at least $500 of non-reimbursable medical, dental, and prescription drug expenses during the Plan Year. With this in mind, you contribute $500 to your health care spending account in equal installments through payroll deduction.

When you have a non-reimbursable medical expense, you pay the bill. You can be reimbursed for these expenses through the FSA by filing a separate claim form or through automatic submission (see page 158).

Contribution Maximums and Minimums

You may elect to contribute up to $2,500 per year to the Health Care Spending Account.

You may elect to contribute up to $2,500 per year to the Health Care Spending Account. There is a minimum contribution of $120 per year. Your contributions will be deducted from your paycheck in equal amounts throughout the Plan Year.

If your spouse (or someone related to you) also maintains a health care spending account, whether through the Company or another employer, this will not affect the maximum amount of your contribution. You may each contribute the maximum amount. ***Please note there is a different rule that applies to contributions to the Dependent Care Spending Account.***

The amount available to you for reimbursement for qualifying expenses from January 1 of the Plan Year is the annual amount you have elected to contribute to the spending account, even if the full amount has not yet been deducted from your pay. For example, if you elect to contribute $1,200 to the spending account, the entire $1,200 will be available to you for reimbursement of your eligible expenses beginning January 1. ***Please note that there is a different rule for reimbursements from the Dependent Care Spending Account.***

Use All the Money In Your Account

You must request reimbursement by March 31 of the following year for health care expenses incurred on or before December 31 of each Plan Year.

The IRS requires that any amounts remaining in your spending account after the deadline for submitting claims for the Plan Year is forfeited. You may not carry forward unused amounts to the next Plan Year, and you may not transfer unused amounts from the Health Care Spending Account to another plan or account, for example, to the Dependent Care Spending Account. Therefore, you should carefully plan the amount of money you will contribute to your spending account.

American Water Works aggregates all forfeitures at the end of each Plan Year and distributes them on an equal basis among the following Plan Year's participants as an addition to their accounts.

You can start, stop, or change the automatic deductions from your paycheck during the calendar year only if you have a change in status (as listed below). The change in status must be on account of, and corresponds with, a change in status affecting eligibility. The following events are changes in status:

- Marriage, death of spouse, divorce, legal separation, or annulment;
- Birth, adoption, placement for adoption, or death of a dependent;
- Termination or commencement of employment by you, your spouse or dependent;
- Reduction or increase in hours of employment by you, your spouse or dependent, including a switch between part-time and full-time, strike or lockout, or taking or returning from an unpaid leave;
- Dependent no longer qualifies because of age, student status, or marriage;
- Change in residence or worksite of you, your spouse or dependent.

You can also start, stop, or change your automatic deductions during the calendar year if the change corresponds with "special enrollment rights" which may apply to you under HIPAA; if you experience a COBRA event; if a judgment, decree, or order resulting from divorce, legal separation, annulment or change in custody requires health coverage for your dependent or dependent foster child; or if you become entitled to Medicare or Medicaid.

Expenses Eligible for Reimbursement

Only "qualifying" expenses can be reimbursed through the Health Care Spending Account. Qualifymg expenses are medical, dental, and vision care expenses incurred by you or an eligible dependent in the diagnosis, treatment, or prevention of disease, including prescription drug expenses and transportation or lodging expenses incurred in receiving treatment. Certain other medical expenses not covered by your medical insurance are also eligible expenses, such as the cost of eye exams. Any deductibles or copayments you have paid under any type of health care plan, including HMOs and vision or dental plans, are also eligible expenses.

Remember. the following lists of eligible and ineligible expenses are not complete. If you have a question as to whether or not an expense is eligible. please call Aetna Member Services at (800) 292-4366.

Remember, though, that the expenses you submit for reimbursement may not be covered by any other insurance or any other source, including a plan sponsored by your spouse's employer, Medicare, Workers' Compensation, automobile insurance, or any recovery or settlement from a law suit.

Below is a list of some of the health care expenses eligible for reimbursement from your spending account. For additional information, call Aetna Member Services at **(800) 292-4366.**

- Acupuncture
- Adoption
- Adult diapers
- Alcoholism treatment
- Ambulance charges
- Artificial insemination
- Birth control
- Braille books/magazines
- Specialized car equipment for disabled persons
- Chiropractic treatment
- Christian Science practitioners
- Coinsuranceldeductibles
- Contact lenses/saline solution
- Copayments
- Cosmetic Surgery:
  - to treat illness/disease
  - to improve a congenital abnormality
  - to treat injury from accident/trauma
  - to improve a disfiguring deformity
- Deductibles

- Dental treatment/orthodontia
- Drug addiction treatments
- Excess of reasonable and customary charges scheduled, annual, or lifetime maximums
- Eye care/exams
- Eyeglasses (prescription only)
- Guide dogs
- Hearing aids/exams
- In-vitro fertilization
- Laboratory fees
- Nursing home costs
- Orthodontia (non-cosmetic only)
- Oxygen
- Prescribed medicines
- Psychiatric treatment
- Smoking cessation programs prescribed by a physician and prescription drugs for the treatment of addiction to nicotine and for alleviation of the effects of nicotine withdrawal *(Note: nicotine gum is not covered because it does not require a prescription by a physician. Nicoderm/Habitrol patches dispensed by a physician are eligible.)*
- Speech therapy
- Sterilization
- Transplants (except hair)
- Vaccinations and immunizations
- Weight loss programs recommended by a physician to treat obesity, provided the reimbursements are recognized by the IRS as "legitimate" medically necessary expenses
- Well-baby care
- Wheelchairs
- X-ray fees

Expenses Not Eligible for Reimbursement

The Health Care Spending Account cannot reimburse any health care expense that is not a qualifying expense. Expenses that cannot be reimbursed include:

- Expenses of someone who is not an eligible dependent,

- Insurance premiums (including COBRA premiums),
- Expenses in excess of the amount you have elected to contribute to the Health Care Spending Account,
- Expenses for general health purposes, such as fitness, exercise, or health club dues unless recommended by a physician for a particular medical condition.
- Expenses for weight loss programs ***unless*** recommended by a physician to treat obesity and the reimbursements are recognized by the IRS as "legitimate" medically necessary expenses.
- Vacation or travel costs to improve health:
- Costs incurred to quit smoking unless prescribed by a physician for the treatment of addiction to nicotine and for alleviation of the effects of nicotine withdrawal,
- Nicotine gum
- Cosmetic surgery, unless necessary to correct a deformity which is congenital or which resulted from a disfiguring illness or an injury resulting from an accident or trauma.
- Bleaching/bonding of teeth
- Non-prescription drugs
- Contact lens insurance
- Vitamins
- Dancing lessons
- Diaper services for children
- Electrolysis
- Funeral expenses
- Hair transplants
- Household help
- Liposuction
- Maternity clothes
- Retin A unless prescribed by a physician for the treatment of acne but not for aging
- Rogaine for a specific medical condition, but not for cosmetic purposes (that is to stimulate growth)
- School tuition
- Swimming lessons
- Transportation costs of a disabled person to and from work
- YMCA/YWCA memberships

This list is intended to give you a general description of expenses not eligible for reimbursement through the spending account. There may be other expenses in addition to those listed above, which are not eligible.

Submitting Claims

You may be reimbursed from your Health Care Spending Account by completing an *FSA Health Care Reimbursement Separate Submission Form.* Check the appropriate section to have eligible expenses paid from your spending account.

Any itemized bills that you submit should contain, at a minimum, the following items:

- The name of the patient and the employee
- The date(s) the services were provided
- A description of the service or item provided
- The name and address of the provider
- The cost of the service or item

Send your completed form to:

Aetna
P.O. Box 3929
Allentown, PA 18106-9861

You will receive an Explanation of Payment (EOP) statement from Aetna detailing the status of your account with each reimbursement.

Family and Medical Leaves of Absence

If you take a Family and Medical Leave of Absence from American Water Works, your contributions via payroll deductions to the Health Care Spending Account will ordinarily stop. You may elect to continue to make deposits to your spending account, on an after-tax basis only, by providing American Water Works with a check for the amount of your desired deposit.

Termination of Employment

If you leave American Water Works, your payroll deduction contributions will cease, although you may elect to make after-tax contributions to the Health Care Spending Account under COBRA. You may still continue to submit claims for reimbursement of expenses incurred **before** your date of termination.

Retirement

If you retire, you must discontinue participation in the Health Care Spending Account.

The Dependent Care Spending Account

The cost of caring for your dependents while you work can be more affordable when you participate in American Water Works Dependent Care Spending Account.

The Dependent Care Spending Account allows you to contribute money on a pretax basis to an account set up for you, and to use that money to pay for qualifying dependent care expenses. The amount contributed to the Dependent Care Spending Account can be used to reimburse you for most day care expenses you might incur for your qualifying dependents. Because contributions to the spending account are not federally taxed, more of your paycheck will be available to you to pay for these costs.

Eligibility

To participate in the Dependent Care Spending Account, you must complete and submit an enrollment form within the 31-day enrollment period. If a signed form is not received within that period. American Water Works will assume that you have decided not to participate in the Plan, and you will not be eligible to participate until the following Plan Year.

All regular full-time employees are eligible to participate in the Dependent Care Spending Account. If you are newly hired, you must enroll in the spending account and make your contribution election ***within the 31-day enrollmentperiod*** You can enroll by completing and signing the Flexible Spending Account section on your ***Enrollment Form.*** You will have the opportunity to change your contribution election in the fall of every year.

Qualifying Dependents

Expenses are reimbursable for care of the following qualifying dependents:

- Your child or other dependent under the age of 13,
- Your spouse who is physically or mentally unable to care for himself or herself, regardless of age, and
- Any other dependent, regardless of age, who lives with you and is physically or mentally incapable of caring for himself/herself.

A "qualifying dependent" for purposes of the Dependent Care Spending Account means your spouse and any person that you claim as a dependent on your federal income tax return. A dependent may not be a person who lives outside of your home; therefore an individual who lives in a nursing home is not a qualifying dependent.

If you are divorced, your children are qualifying dependents only if you (or your new spouse, if filing jointly) provide more than half of their support. "Support" includes food, clothing, shelter, education, and medical care. Generally, if you had custody of the child for most of the year, the child is a qualifying dependent, provided he or she is under the age of **13.** You should consult your tax advisor to determine whether an individual qualifies as your dependent.

If two married or related American Water Works employees both maintain Dependent Care Spending Accounts, an expense incurred on behalf of their dependent may be submitted only to one spending account for reimbursement. Double reimbursement is never permitted.

How the Account Works

Let's assume you know that your children will need daycare costing $2,400 during the year, so you elect to deposit $2,400 into your Dependent Care Spending Account through payroll deduction. When the first daycare bill becomes due, you pay the bill and submit a reimbursement claim to Aetna, along with a copy of the bill. You will then be reimbursed from your account, **assuming that you have an adequate balance in your account.** If not, your claim will be pended until such time as the balance in your Dependent Care Spending Account is sufficient to cover the bill.

Keep in mind, however, that because you will contribute to the spending account through payroll deductions, you will have aperiod of increased expenses. You will have to pay your dependent care provider, as well as have payroll deductions, before receiving reimbursements from your account.

Remember to plan your contribution carefully, since you will forfeit any unused amounts, and you are not permitted either to change or stop your contributions during the year unless you have an eligible change in family or employment status.

Maximum and Minimum Deposits

The amount of your contributions (combined with those of your spouse) to your Dependent Care Spending Account may not exceed $5,000.

Generally, you may elect to contribute up to a maximum of $5,000 per year, regardless of the actual number of qualifying dependents you have, or $2,500 per year if you are mamed but file a separate tax return. If your spouse also maintains a Dependent Care Spending Account, whether through American Water Works or another employer, and you file a joint tax return, the $5,000 limit will apply to the total contributions both of you make to your respective accounts. For example, if your spouse contributes $4,000 to his or her account, you may contribute only $1,000 to your Dependent Care Spending Account.

Special Rules

In addition, your Dependent Care Spending Account contribution can never be more than your earned wages or your spouse's earned wages, whichever is **less.** If your spouse is either a full-time student or physically or mentally incapable of caring for himself or herself, your maximum contribution to the spending account will be $1,200 per year if you have one qualifying dependent, or $4,800 per year if you have two or more qualifying dependents. A "full-time student" as defined by the IRS for the purposes of the Flexible Spending Account is an individual who maintains status as a full-time student at a college or university during at least five months of the year.

Determining How Much to Deposit

The amount you elect to contribute will depend upon the amount you anticipate you will need to cover your dependent care expenses. You should compare the tax benefit that you will receive with the Dependent Care Spending Account to the benefit that you would receive with the federal child and dependent care tax credit, and then choose between them. For additional details about the federal tax credit, you may wish to obtain IRS Publication 503 ("Child and Dependent Day Care Credit") from your local IRS office.

Use All the Money in Your Account

You must request reimbursement by March 31 of the following year for dependent care expenses incurred on or before December 31 of each Plan Year. At the end of each calendar year, the IRS requires that you forfeit any money left in your Dependent Care Spending Account. You may not carry forward unused amounts to the next Plan Year, nor may you transfer unused amounts from your dependent care spending account to another plan or account, for example, to the Health Care Spending Account. For this reason, it is important that you carefully plan your deposit amounts.

American Water Works aggregates all forfeitures at the end of each Plan Year and distributes them on an equal basis among the following Plan Year's participants as an addition to their accounts.

Expenses Eligible for Reimbursement

Eligible expenses include dependent care expenses that enable you and your spouse to work or your spouse to attend school full-time while you work. Such expenses include but are not limited to the following. For additional information, call Aetna Member Services at **(800) 292-4366.**

You may receive reimbursement from your account for expenses that have been incurred for services rendered during the Plan Year. In order to be reimbursed for these expenses. the tax ID number or Social Security number of the provider must be submitted.

- A qualified child or adult day care center that receives payment for the care of more than six individuals who do not reside there,
- Wages paid to a baby-sitter or companion, whether in your home or elsewhere, during the time that you are working,
- A housekeeper whose duties include dependent care,
- A relative who cares for your dependents, but is neither your dependent nor your child under age 19,
- Someone who cares for an elderly or disabled dependent in your home,
- Summer day camp expenses, provided that the camp is NOT for a specific educational purpose, such as learning tennis or computers, and the care is necessary in order for you or your spouse to work (or for your spouse to attend school full-time while you work),
- Nursery school expenses, provided that the school is a state-licensed facility.

Remember, the care must be necessary so that you and, if you are mamed, your spouse can work. If your spouse does not work, dependent care expenses are not eligible, unless you work and your spouse is a full-time student or physically or mentally unable to care for him/herself.

Expenses Not Eligible for Reimbursement

Private school tuition (except private kindergarten) is not reimbursable. Transportation costs to and from the location where the care or program is provided are also not reimbursable, unless the transportation cost is part of the cost of the program. Other expenses ineligible for reimbursement are as follows:

- Expenses for food, clothing, education, or entertainment you incur for the normal care of an eligible dependent, unless these expenses are incidental and cannot be separated from the cost of care
- 24-hour-a-day nursing home expenses
- Cost for child care that enables your spouse to do volunteer work
- Private kindergarten expenses, or
- Educational expenses for children in the first grade or higher
- Overnight camp expenses
- Payments for baby-sitters when you are not working, such as in the evening or on weekends

This list is intended to give you a general description of expenses not eligible for reimbursement through the spending account. There may

be other expenses in addition to those listed above, which are not eligible.

Changing or Stopping Payroll Deductions

You can start, stop, or change the automatic deductions from your paycheck during the calendar year only if you have a change in status (as listed below). The change in status must be on account of, and corresponds with, a change in status affecting eligibility. The following events are changes in status:

- Marriage, death of spouse, divorce, legal separation, or annulment;
- Birth, adoption, placement for adoption, or death of a dependent;
- Termination or commencement of employm'ent by you, your spouse or dependent;
- Reduction or increase in hours of employment by you, your spouse or dependent, including a switch between part-time and full-time, strike or lockout, or taking or returning from an unpaid leave;
- Dependent no longer qualifies because of age, student status, or marriage;
- Change in residence or worksite of you, your spouse or dependent.

You may also start, stop or change the automatic deductions because of a change in cost or coverage, as follows:

- Significant increase or decrease in the cost of dependent care (only if changed by a dependent care provider who is not an employee's relative);
- Addition, elimination, or significant curtailment of the Association's benefits (or those of the spouse or dependent's employer) which reduces coverage;
- Enrollment period for spouse's or dependent's plan is different than the Association's (if the spouse or dependent makes changes in coverage).

Changing caregivers during the year does not constitute a qualified change in family status, nor does the fact that your child reaches age 13 during the Plan Year. You should consider the possibility of these events when you plan your payroll deductions.

Submitting Claims

You should submit a Dependent Care Reimbursement Form to Aetna, along with proof of payment for the services (e.g., receipts, statements, canceled checks, etc.). At a minimum, you must inform Aetna of:

- The dependent's name and age,
- The nature of the care provided,
- The date(s) the care was provided,
- The amount paid for the care,
- The dependent's relationship to you, and

- The name and taxpayer identification number (or Social Security number) of the care provider.

Claim forms are available from your Human Resources representative, or from Aetna. Remember that you are entitled to reimbursement only after the care has been provided. If you pay for dependent care in advance, you may not be reimbursed until the care has been provided.

Send your completed claim form:

Aetna
P.O. Box 3929
Allentown, PA 18106-9861

You will receive an Explanation of Payment (EOP) statement from Aetna detailing the status of your account with each reimbursement.

Family and Medical Leaves of Absence

If you take a Family and Medical Leave of Absence from American Water Works, your contributions via payroll deductions to the Dependent Care Spending Account will stop. You may submit claims for reimbursement for care provided through your last day of work before your leave began.

Termination of Employment

If you leave American Water Works, you can still continue to submit claims for reimbursement of expenses incurred before your date of termination. Expenses for care provided after your date of termination are not eligible for reimbursement. COBRA continuation coverage does not apply to the Dependent Care Spending Account.

Retirement

If you retire, you must discontinue participation in the Dependent Care Spending Account.

Short Term Disability (STD)

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Short Term Disability Benefits

After a waiting period, this plan will pay the Short Term Disability Insurance benefit of $250 for each week of a disability absence, (unless superseded by State law). The absence must start while you are covered under the Plan. A disability absence is lost time from work because of a non-occupational injury or illness (or one which results from work with AWS).

The benefit amount will be reduced by any weekly amount you are eligible for under any Worker's Compensation or other like law for time lost from work.

Benefits start after the first 7 days of a disability period due to illness, including pregnancy. Benefits start on the first day of a disability due to injury. You will not be eligible for STD benefits for any period of time in which you are eligible to receive Company paid sick leave and in no event will the combination of a Company paid sick leave and STD benefits exceed 52 weeks.

A physician's certification that you are disabled because of the condition will be necessary. Further, Aetna may request any additional evidence it believes is necessary before deciding that benefits are payable.

More than one disability absence will he part of the same period of disability:

- If it is due to the same or a related cause, and
- If it is separated by less than two consecutive weeks of full time work.

You will be eligible for a new maximum Period of Payment if:

- A new disability absence is due to a cause different from that of any prior disability, and
- It is separated from the prior disability by at least one day of full-time active work.

Limitations

No benefits are payable for:

Days on which you do work for pay or profit.

Any period of time you are not under the care of a physician. You must have been seen in person and treated by a physician to be deemed under his or her care.

Coverage for Occupational Illness or Injury

This Plan pays a weekly benefit if you are absent from work, while covered, because of an illness or injury resulting from employment with American Water Works. However, the Weekly Benefit amount will be reduced by the weekly amount for which you are eligible for time lost under any Workers' Compensation law or any other similar law or doctrine. This benefit runs concurrent with sick leave.

Submitting Claims

To apply for benefits under the Short Term Disability Plan, you should contact Aetna Managed Disability at **(800) 804-5329.**

To receive disability benefits, you must file a claim within 31 days of your disability. Benefits will begin as soon as Aetna receives the information to verify your disability.

While you are receiving Short Term Disability, you may be required periodically to provide Aetna with additional medical information from your physician documenting your continued disability. Aetna also may require that an appointed physician examine you in order to verify your disability. It is your responsibility to provide Aetna with the requested documentation supporting your claim, or your benefits will stop.

Life Insurance

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Life Insurance Benefits

Life Insurance Benefits include Basic, Optional, Voluntary Life Insurance and Accidental Death and Dismemberment Insurance

Eligibility

If you are a regular full-time American Water Works union employee covered under the national benefits Memorandum of Agreement, you are eligible to participate in American Water Works Life Insurance Benefit Plans. Your eligibility date is the first day of the month, following completion of one full month of continuous service with the Company.

Participation in the plans you select begins on the first day of the month, following completion of one full month of continuous service with the Company, provided you are then actively working or would have been able to work had you been scheduled to work that day. If you are on a layoff, on disability, or on a leave of absence on your eligibility date, coverage will not begin unless it has been elected and upon your return to active status.

The Basic Life Insurance Plan

Life insurance is an important financial asset and should be included in your long-term financial security planning. American Water Works provides you with a Basic Life Insurance benefit automatically, at no cost to you.

Your life insurance amount is equal to 1 times your base pay rounded to the next $1,000. Your life insurance amount will increase automatically with rate increases. Your life insurance benefit is calculated based on your normally scheduled hours, excluding overtime. The maximum benefit is $50,000.

This is an insured plan underwritten by Aetna. The provisions of the Plan will remain effective only while you are covered under the group contract.

Accelerated Death Benefits

If you (or your spouse) become terminally ill while covered under the Life Insurance program, you may request that Aetna pay an Accelerated Death Benefit.

"Terminally ill" is defined as a person who:

- suffers from an incurable, progressive, and medically recognized disease or condition; and
- to a reasonable medical probability and based on a generally accepted prognostic

  Protocol, will not survive more than the Accelerated Death Benefit months beyond the date of the request for the Accelerated Death Benefit.

You may request an Accelerated Death Benefit on your own behalf or on behalf of your spouse at any time by completing an Aetna Request for Accelerated Death Benefit Form and submitting it to Aetna. The request must include the statement of a currently licensed United States physician that you or your spouse is terminally ill.

The physician's statement must include:

- all medical test results
- laboratory reports; and
- any other information on which the statement is based, including the generally accepted prognostic protocol used by the physician to determine the person's expected remaining life span.

Your request for an Accelerated Death Benefit must state the amount of the benefit requested. The Plan includes an Accelerated Death Benefit of *50%* of your normal death benefit to you or your spouse in the event of a terminal illness. The Accelerated Death Benefit Minimum is *$5,000* and the Accelerated Death Benefit Maximum is *$300,000.*

This benefit can be requested only once on your own behalf and once for your spouse. If someone other than you is the owner of your Life Insurance Coverage for you and your spouse the Accelerated Death Benefit will not be available under this Plan for or on behalf of such person.

Age Reduction Rule

Your Life Insurance amount in force on the day before the first day of the month in which you reach age 70 will be reduced by:

- 35% at age 70
- 50% at age 75

No reduction under this provision will take place if your Life Insurance has already been reduced because of retirement, however, see below for any further reductions that apply during your retirement.

If you become insured during or after the month in which you reach the above ages, your amount of Life Insurance will be the applicable percentage of the amount shown for your classification.

Retirement Reduction Rule

If you retire prior to January 1, 2003 and you remain in an Eligible Class, your Basic Life Insurance will remain in force during your retirement, subject to change or termination in accordance with the terms of the group contract. Your Basic Life Insurance as of the date you retire will be:

100% of your basic annual earnings, as determined by your Employer, rounded to the next higher $ 1,000, if not an integral multiple of $ 1,000.

- Maximum: $50,000
- Minimum: $ 1,000

If your Basic Life Insurance has already been reduced in accordance with the Age Reduction Rule shown above, the amount of Basic Life Insurance then in force will remain in force.

The Life Insurance amounts in force for you at retirement will be reduced by 10% on the first anniversary of the date you retire. The reduced amount will be further reduced by the same dollar amount on each of the next four anniversaries of the first reduction, until the amount reaches 50% of what was in force before any age or retirement reductions were applied.

If you retire on or after January 1,2003, your retiree Life Insurance benefit will be $10,000.

Life Insurance After Termination

In most cases, you may apply for an individual policy under the Conversion Privilege within 31 days after your American Water Works Life Insurance ceases. If you die during this 31 days and before the individual policy goes into effect, the amount payable under the group policy is limited to the maximum that could have been converted. The limit applies even if you have not applied for or paid the first premium on the individual policy. This applies to basic, optional and voluntary life insurance.

Conversion of Your Life Insurance

If any of your life insurance ceases because your employment ceases or you are no longer in a class eligible for such insurance, or because of age, pension, or retirement, the amount of insurance which ceases (or a lesser amount if desired) may be converted to an individual life insurance policy. This applies to basic, optional and voluntary life insurance.

Your converted policy may be any kind of individual policy then customarily being issued by Aetna for the amount being converted and for your age (nearest birthday) on the date it will be issued, except a term policy or one with disability or other supplementary benefits.

When life insurance ceases because that part of the group contract discontinues as to your employee class, and insurance on the life of the person has been in force under the group contract for at least five years in a row prior to such discontinuance, the amount that ceases less the amount of any group life insurance for which the person becomes eligible within 31 days of discontinuance may be converted to an individual policy. The maximum amount that can be converted by each person in any event is $10,000.

In order to convert, written application must be made for an individual policy and the first premium must be paid on it within 31 days after cessation of insurance for any of the above reasons. No evidence of insurability will be required. The individual policy will become effective at the end of the 31-day period during which conversion is possible.

The premiums for the converted policy will be at Aema's then customary rates for the same policy issued to any other person of the same class of risk and age at the time the converted policy is to become effective.

After an individual policy becomes effective for any person, that policy will be in exchange for all benefits and privileges under the group contract as regards the person involved and the amount that could have been converted.

In most cases, you may apply for an individual policy under the Conversion Privilege within 31 days after your American Water Works life insurance ceases. If you die during this 31 days and before the individual policy goes into effect, the amount payable under the group policy is limited to the maximum that could have been converted. The limit applies even if you have not applied for or paid the first premium on the individual policy.

Effect of Prior Coverage

If the coverage of any person under any part of this Plan replaces any prior coverage of the person, the rules below apply to that part.

"Prior coverage" is any plan of group insurance that has been replaced by coverage under part or all of this Plan. It must have been sponsored

by American Water Works. The replacement can be complete or in part for the Eligible Class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this Plan.

A person's life insurance under this Plan replaces and supersedes any prior life insurance. It will be in exchange for everything under the prior life insurance. If you or your beneficiary becomes entitled to claim under the prior life insurance, your Life Insurance under this Plan will be canceled. This will be done as of its effective date. Any premiums paid for your life insurance under this Plan will be returned to American Water Works.

The mode of settlement you chose and the beneficiary you named under a prior Aetna plan will apply to this Plan. This can be changed according to the terms of this Plan.

Voluntary Employee Group Term Life Insurance

Voluntary Life Insurance

Voluntary Employee Group Term Life Insurance offers employees an opportunity to elect additional amounts of term life insurance on a contributory basis.

Voluntary Life Insurance offers employees an opportunity to elect additional amounts of term life insurance on a contributory basis.

In addition to Company-paid life insurance, you will have the option of electing additional life insurance coverage ranging from 1 to 3 times your base pay, up to a maximum benefit of $1,000,000. For initial enrollment in voluntary life insurance, proof of good health will be required for coverage over $300,000. You must be actively at work in order for coverage to take effect.

You can also elect additional employee paid life insurance coverage of $20,000 for your spouse and $10,000 for each dependent. Eligible dependents include children age 14 days to age 19, or to age 23 if a full time student.

Employees enrolled in this Plan have coverage as indicated in the following chart.

Life Insurance Choices			
• No voluntary hfe Insurance			
Voluntary life insurance of 1x base pay			
• Voluntary life insurance of 2x base pay			
• Voluntary life insurance of 3x base pay			
Voluntary Life Insurance premium Levels (per $1,000 of Base Pay)*			
Age	**Monthly Cost**	**Age**	**Monthly Cost**
Under 30	$0.06	55-59	$0.63
30-34	$0 08	60-64	$0.75
35-39	$0.10	65-69	$1.37
40-44	$0.12	70-74	$2.21
45-49	$0.20	over 75	$3.67
50-54	$0.35		
Rates are subject to change.			

Spouse and Dependent Life Insurance Choices	Monthly Cost
No coverage for your spouse	$0
$20,000 coverage for your spouse	$5.80
No coverage for your dependents(s)	$0
$10,000 coverage for each dependent	$1.20 for each dependent

Optional Employee Group Term Life Insurance

Optional Employee Group Term Life Insurance offers employees an opportunity to elect additional amounts of term life insurance on a contributory basis. Only employees who were participating on December 31, 1995, may continue this optional coverage.

Participation in the current Optional Employee Group Term Life Insurance was frozen as of December 31, 1995. If you are currently enrolled in either of the two options of this Plan, your participation will continue. Participants' life insurance amounts will increase as their salary increases, according to the following Plan options:

- **Option A: 100%** of your Salary Scheduled Amount, up to $40,000 of coverage.
- **Option B:** 50% of your Salary Scheduled Amount, up to $20,000 of coverage.

Employees enrolled in this Plan have coverage as indicated in the following chart.

Salary Scheduled Amount of Optional Coverage

Annual Basic Earnings			Insurance	
			Option A (100%)	**Option B (50%)**
$38,000	or more		$40,000	$20,000
$35,000	but less than	$38,000	$38,000	$19,000
$32,000	but less than	$35,000	$35,000	$17,500
$29,000	but less than	$32,000	$32,000	$16,000
$26,000	but less than	$29,000	$29,000	$14,500
$22,500	but less than	$26,000	$26,000	$13,000
$19,500	but less than	$22,500	$23,000	$11,500
$16,500	but less than	$19,500	$20,000	$10,000
$13,500	but less than	$16,500	$17,000	$8,500
$10,400	but less than	$13,500	$14,000	$7,000
$7,280	but less than	$10,400	$10,000	$5,000
$5,200	but less than	$7,280	$7,000	$3,500
less than $5,200			$5,000	$2,500

This Basic and Optional Plan will pay a life insurance benefit equal to the amount of life insurance in force for you if you die from any cause while insured.

Beneficiaries

When you elect to participate in any of these Plans, you will designate a Beneficiary(ies).

You may name or change your beneficiary by submitting a Beneficiary Designation Form, which is available at your Human Resources office. The naming or any change will take effect as of the date you execute the request. Aema will be fully discharged of its duties as to any payment made by it before your request is received at its Home Office.

Any amount payable to a beneficiary will be paid to those you name. Unless you state otherwise, if more than one beneficiary is named, they will share on equal terms.

If a named beneficiary dies before you, his or her share will be payable in equal shares to any other named beneficiaries who survive you.

If no named beneficiary survives you or if no beneficiary has been named, payment will be made as follows to those who survive you:

- Your spouse, if any.
- If there is no spouse, in equal shares to your children.
- If there is no spouse or child, to your parents, equally or to the survivor.
- If there is no spouse, child, or parent, in equal shares to your brothers and sisters.
- If none of the above survives, to your executors or administrators.

Permanent and Total Disability Benefits

For the purposes of the benefit, you are considered permanently and totally disabled only if:

- An illness or injury stops you from working at:
  - your own job, or
  - any other job for pay or profit,

  and it must continue to prevent you, for life, from working at any reasonable job. A "reasonable job" is any job for pay or profit, which you are, or may reasonably become, fitted for by education, training, or experience, or
- You lose one of these functions:
  - the sight of both eyes,
  - the use of both hands,
  - the use of both feet,
  - the use of one hand and one foot

You must meet all of the following to be eligible for a Permanent and Total Disability benefit:

- Your Life Insurance must be in force when you become permanently and totally disabled.
- You must be under age 60 when you are first permanently and totally disabled.

  You must furnish all proof when requested. Aetna has the right to examine you, at its expense, before approving the proof.

Permanent and Total Disability for Employees With 10 or More Years of Continuous Service

If you are under age 65 with 10 or more years of continuous service with American Water Works and you are permanently and totally disabled while insured under the Plan so you can do no work for pay . or profit, and if you furnish all information, notices, and proof when required, the amount of your life insurance in force at the time of the disability may he extended during the disability, without payment of premiums and contributions. The duration, nature, and extent of disability determine eligibility for this extension.

Any total disability should be reported immediately to American Water Works for help in determining whether you qualify for this extended insurance and the amount of insurance that may be continued. Refer to the Age Reduction Rule and Conversion Privilege, which may apply to this life insurance amount. In addition, you may also be eligible for the Disability Monthly Income Benefits described in the following section.

Permanent and Total Disability for Employees With Less Than 10 Years of Continuous Service

If you become eligible for a Permanent and Total Disability benefit and the disability lasts for six months or more, a monthly income of $18 for each $1,000 of the amount of your basic and optional insurance is payable. The monthly income will continue until the amount of your insurance, plus interest as may be declared by Aetna on the unpaid balance, is exhausted.

Permanent and Total Disability Monthly Income Benefits

Aetna must receive written notice of claim at its Home Office within 12 months after you stop active work. Proof of the permanent and total disability must be received no iater than 12 months after premium payments stop.

Monthly income payments will cease on the earliest to occur of:

- The date payments equal the amount of your life insurance in force when the disability began, plus interest on the unpaid balance.

  The date Aetna sends you a request at your last address shown on Aetna records:

  - for an exam, if you do not go for the exam, within 31 days of that date.
  - for proof that you are still permanently and totally disabled, if proof is not given within the 31 days of that date.

  The date you are well enough to work in any reasonable job

- The date you start to work in any job for pay or profit,

When monthly income payments stop, except for the reason that you have been fully paid, you will be eligible to convert to an individual life insurance policy, as described in the "Conversion Privilege" section, as if your employment had then ceased. However, if you become eligible for life insurance under any group policy within 31 days of the date the payments stop, the privilege is not allowed. The amount of the individual policy under the Conversion Privilege will not be more than the amount of your life insurance in force when the

disability began, less the total amount of monthly income payments, which had been made.

Aetna will calculate the rate of interest on the unpaid balance. It will not be less than the rate guaranteed for installment methods of settlement under an Aetna individual life insurance policy on the date the first monthly income payment is due.

After monthly income payments have been made for two years in a row, Aetna will not request an exam or proof of disability more often than once every 12 months.

If you die after Aetna has approved the disability benefit but before monthly income payments start, the amount of Life Insurance in force for you when the disability began will be paid to the beneficiary.

If you die while monthly income payments are being made, any balance will be paid in a lump sum to the beneficiary.

If you have once had a claim approved and again become eligible for coverage, the amount of that coverage will be reduced by the monthly payments, which have been made to you. Aetna may waive this in writing until it approves another claim for you.

Extended Death Benefit

If Aetna receives proof, at its Home Office, that all of the following apply, it will pay your beneficiary, as a Permanent and Total Disability benefit, the amount of life insurance in force on your life when the total disability began:

- Premium payments for your life insurance cease while you are totally disabled by illness or injury, which stops you from working in any reasonable job.
- You die during the uninterrupted continuance of the total disability. Death occurs no later than 12 months after premium payments from American Water Works cease.
- You would have qualified for the Permanent and Total Disability benefit except that:
  - your total disability had not lasted at least six months, or
  - the required proof has not yet been received or approved by Aetna.

Written notice of your death must be given to Aetna at its Home Office within 12 months of your death. If it is not given, Aetna will not have to pay this benefit.

When Aetna approves a claim for any benefit under this feature, the benefit will be in full settlement and satisfaction of Aetna's obligations.

If any individual policy has been issued to you under the Conversion Privilege, your rights under this section may be restored. In order to

restore those rights, you must give up all such policies without claim, except for the return of the premiums you paid.

Accidental Death and Dismemberment Coverage (AD&D)

This Accidental Death and Dismemberment (AD&D) benefit is an insured plan underwritten by the Aetna. The provisions of the Plan will remain effective only while you are covered under the group contract. This Plan pays up to a $10,000 benefit if, while insured, you suffer a bodily injury in an accident and if, within 90 days after the accident, you lose, as a direct result of the injury:

- Your life
- A hand, at or above the wrist joint.
- A foot, at or above the ankle joint.
- An eye, involving irrecoverable and complete loss of sight in the eye.

Your full $10,000 Principal Sum is payable for loss of life. Half your $10,000 ($5,000) Principal Sum is payable for loss of a hand, loss of a foot, or loss of an eye. No more than $10,000 is payable for all losses which result from one accident. Benefits are paid for losses caused by accidents only.

No benefits are payable for a loss caused ***or*** *contributed to* ***by:***

- Bodily or mental infirmity.
- Disease, ptomaines, or bacterial infections.
- Medical or surgical treatment.
- Suicide or attempted suicide (sane or insane).
- Intentionally self-inflicted injury.
- War or any act of war (declared or undeclared).
- Participation in a riot or an attempt or commission of a felony.

These limitations do not apply if the loss is caused by:

- An infection, which results directly from the injury.
- Surgery needed because of the injury.

Submitting Claims

For Survivor's Benefits

To receive survivor's benefits under the Basic Life Insurance Plan or Optional Employee Group Term Life Plan, or Voluntary Life Insurance Plan, your beneficiary must complete and submit tbe appropriate *Statement* of *Claim* form and provide a certified death certificate to your Human Resources representative within one year of your death.

If you were totally disabled at the time of your death and American Water Works was continuing your coverages at no cost to you, your beneficiary may be required to submit proof that total disability was continuous up to the date of your death.

For AD&D Benefits

To receive AD&D benefits you must complete and submit the appropriate Statement of Claim form and provide proof documenting your loss to your Human Resources representative within 30 days after the loss occurs. In some cases, you may be requested to undergo an independent medical examination before benefits can be paid.

How Benefits Are Paid

Approved Survivors' and AD&D claims are paid in a lump sum. However, other payment options may be available from Aetna. Your Human Resources representative will provide information about optional payment methods when you or your beneficiary are eligible to receive benefits.

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Plan Information

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974, as amended (ERISA). This information, together with the information contained in this hook, is the Summary Plan Description required by ERISA.

- Employer Identification Number

  51-0063696

- Plan Number

  501

- Type **of Plan**

  Health and Welfare Benefit Plan

- Type of Administration

  Self-Insured/Administrative Services Contract

- Plan Administrator

  Vice President, Human Resources
  American Water Works Company, Inc.
  1025 Laurel Oak Road
  Voorhees, NJ 08043

- Agent for Service of Legal Process

  The Secretary
  American Water Works Company, Inc.
  1025 Laurel Oak Road
  Voorhees. NJ 08043

- End of Plan Year

  December 31st

- Source of Contributions

  Employer and Employee

Amendment or Termination of a Plan

The Right to Amend or Terminate the Plan

The Company expects to continue this Plan, but reserves the right to amend it, or terminate it, at any time, in whole or in part. The authority to make any such changes to the Plan generally rests with the Board of Directors of American Water Works, although the Plan Administrator may also change the Plan as required by law or in a manner which will not result in a material cost. Some of the employees who participate in this Plan do so under the terms of collective bargaining agreements. The Company takes its obligations under those agreements very seriously and will, as required either by the Company's contractual agreements or by law, negotiate changes to the Plan affecting union members with those unions whose members participate in the Plan.

Claims Review and Appeals Process

If your claim is denied in whole or in part, or if you feel an error has occurred in processing your claim for benefits you should be aware that the following appeals procedure is available.

A claim is a request for a plan benefit by you or your dependent. Several of the benefit programs or plans under the Health and Welfare Benefit Plan may require you to file a claim to receive a benefit. If your claim is denied in whole or in part, or if you feel an error has occurred in processing your claim for benefits you should be aware that the following appeals procedure is available to you, your dependent or any other person who claims a right to benefits under a plan.

If you have questions about the denial of a claim, you should first contact the Claims Administrator. The Claims Administrator will state specific reasons for the denial, references to pertinent sections in the plan document, additional information you must provide to improve your claim, and the procedure available for further review of your claim. If you believe your benefits under a plan were denied improperly, or you do not agree with the reasons for denial of your claim, you may request a review.

The Claims and Plan Administrators have full discretion and authority to determine all claims under the Plan. Any action or determination in this review procedure will be final, conclusive and binding on the

Claims Administrator, the Company, the Plan Participant and the Participant's family members.

CLAIMS SUBMITTED ON OR BEFORE DECEMBER 31.2002 (PRE-2003 CLAIMS)

Claims Denial Procedure

If your claim for a benefit is denied in whole or in part, you will receive a written explanation of the reason for the denial from the Claims Administrator within 90 days after filing a claim. If special circumstances apply, the Claims Administrator may take up to an additional 90 days to contact you. However, the Claims Administrator must notify you of this extension before the end of the initial 90-day period.

How to Appeal a Claim

If you believe your claim for benefits was improperly denied, you may submit a written request for a review of the denial of the claim to the Plan Administrator. In your request for a review, you must state the reasons that you believe your claim was improperly denied and include all additional information that you consider relevant in support of your claim. You also have the right to request and review all documents relevant to the denial of your claim. Your complete request for a full and fair review must be received by the Plan Administrator within 60 days from the date you receive the denial.

Disability Claims Denial Procedure

. If your disability claim is denied in whole or in part, you will receive a written explanation of the reason for the denial from the Claims Administrator within 45 days after filing the claim. If special circumstances apply, this initial 45-day period may be extended twice, up to 30 days for each extension. However, the Claims Administrator must:

- notify you of an extension prior to the beginning of the extension period,
- provide the circumstances requiring the extension of time, and the
- date by which the Plan expects to render a decision.

If an extension is needed, the written notice you receive will include:

the specific reasons for the denial

- the unresolved issues that prevent a decision on the claim, and
- the additional information needed to resolve those issues

You will be allowed at least 45 days within which to provide the specified information.

How to Appeal a Disability Claim

If you believe your claim for disability benefits was improperly denied, you may request a review of the denial in writing. Your complete request must be received by the Plan Administrator within 180 days from the date you receive notice of the denial. The full and fair review will be held and a decision rendered by the Plan Administrator no longer than 45 days after receipt of the request for the review.

If special circumstances apply, the decision will be made as soon as possible, but not later than 90 days after receipt of the request for review. If such an extension of time is needed, you will be notified in writing prior to the beginning of the extension period. Once a decision is determined, you will receive a written notice, which will include specific reasons for the decision as well as specific references to the pertinent Plan provisions on which the decision is based.

CLAIMS SUBMITTED ON OR AFTER JANUARY 1, 2003 (POST-2002 CLAIMS)

Claims Denial Procedure

If your claim for a benefit is denied in whole or in part, you will be notified in writing of the Adverse Benefit Determination within 90 days of filing the claim. If special circumstances apply, the Claims Administrator may take an extension of up to an additional 90 days to contact you. However, the Claims Administrator must notify you of this extension before the end of the initial 90-day period.

How to Appeal a Claim

If yon believe your claim for benefits was improperly denied, you may submit a written request for a review of the denial of the claim to the Plan Administer. In your request for a review, you must state the reasons that you believe your claim was improperly denied and include all additional information that you consider relevant in support of your claim. You also have the right to request and review all documents relevant to the denial of your claim. Your complete request for a full and fair review, must be received by the Plan Administrator within *60* days from the date you receive notice of the denial.

Disability Claims Denial Procedure

If your disability claim is denied in whole or in part, you will receive a written explanation of the reason for the denial from the Claims Administrator within 45 days after filing the claim. If special circumstances apply, this initial 45-day period may be extended twice, up to 30 days for each extension. However, the Claims Administrator must:

- notify you of an extension prior to the beginning of the extension period,

- provide the circumstances requiring the extension of time, and the
- date by which the Plan expects to render a decision

If an extension is needed, the written notice you receive will include:

- the specific reasons for the denial
- the unresolved issues that prevent a decision on the claim: and
- the additional information needed to resolve those issues

You will be allowed at least 45 days within which to provide the specified information.

How to Appeal a Disability Claim

If you believe your claim for disability benefits was improperly denied, you may request a review of the denial in writing. Your complete request must be received by the Plan Administrator within 180 days from the date you receive notice of the denial. The full and fair review will be held and a decision rendered by the Plan Administrator no longer than 45 days after receipt of the request for the review.

If special circumstances apply, the decision will be made as soon as possible, but not later than 90 days after receipt of the request for review. If such an extension of time is needed, you will be notified in writing prior to the beginning of the extension period. Once a decision is determined, you will receive a written notice, which will include specific reasons for the decision as well as specific references to the pertinent Plan provisions on which the decision is based.

Urgent Care Claims

An "urgent care claim" is a claim for medical care or treatment where a delay could seriously jeopardize the life or health of the person bringing the claim or which would, in the opinion of the physician, subject that person to severe pain which could not be managed without the care or treatment related to the claim.

For an urgent care claim, the Claims Administrator will notify you of the Plan's determination within 72 hours after receipt of the claim by the Plan, unless you fail to provide sufficient information to make a determination. If information is missing, you will be notified within 24 hours after receipt of the claim by the Plan of the specific information necessary to complete the claim. You will be given at least 48 hours to provide this information. You will be notified of the Plan's determination within 48 hours after the earlier of:

- the Plan's receipt of the missing information, or
- the end of the period given to you to provide the missing information.

The Plan will notify you of a determination within 72 hours of the Plan's receipt of your request for review of an Adverse Benefit Determination. To expedite the review process, you may submit a request for an appeal of a claim that has been denied either orally or in writing and all necessary information may be communicated by phone. fax or other available option.

Pre-Service Claims

A "pre-service claim" is a claim for a benefit where approval must be granted for the benefit by the Claims Administrator before you receive medical care or treatment. If the Plan denies your request for a pre-service claim, you will be notified of the Plan's determination within 15 days after receipt of the claim by the Plan. If special circumstances apply, this period may be extended one time for up to 15 days. However, the Claims Administrator must notify you of

- this extension before the end of the initial 15-day period,
- the circumstances requiring the extension of time; and
- the date by which the Plan expects to render a decision.

If the extension is necessary due to missing information, the notice of extension will specifically describe the required information and give you at least 45 days from receipt of the notice to provide the missing information.

The Plan will notify you of a determination within 30 days of the Plan's receipt of your request for review of a claim that has been denied.

Post-Service Claims

A "post-service claim" is a claim for a benefit that does not require approval before receiving treatment. If the Plan denies your request for a post-service claim, you will be notified of the Plan's determination within 30 days after receipt of the claim by the Plan. If special circumstances apply, this period may be extended one time for up to 15 days. However, the Claims Administrator must notify you of:

- this extension before the end of the initial 30-day period,
- the circumstances requiring the extension of time; and
- the date by which the Plan expects to render a decision.

If the extension is necessary due to missing information, the notice of extension will specifically describe the required information and give you at least 45 days from receipt of the notice to provide the missing information.

The Plan will notify you of a determination within 60 days of the Plan's receipt of your request for review of an Adverse Benefit Determination.

Your Rights Under ERISA

What Are Your Rights?

The intent of this book is to meet the Summary Plan Description requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA). However, if there is a conflict between the information contained in the official Plan documents and the information contained in this book, the information in the Plan documents will take precedence.

Under ERISA, you are entitled to:

- Examine, without charge, all Plan documents at the Plan Administrator's office, including all contracts and copies of any documents filed by American Water Works Medical Plan with the U.S. Department of Labor (such as detailed annual reports and Plan descriptions).
- Obtain copies of all Plan documents and other program information, by writing to the Plan Administrator. The Plan Administrator may charge a reasonable fee for the copies.
- Receive each year a summary of American Water Works Employee Benefit Plan's annual financial report.

ERISA also spells out the obligations of the "Plan Fiduciaries" (the people responsible for the Plan's operation). These obligations are as follows:

The Plan Fiduciaries must operate American Water Works Employee Benefit Plans prudently, in the interests of you and other participants and beneficiaries.

You cannot be fired, disciplined, or otherwise discriminated against in any manner that would interfere with or prevent you from obtaining a benefit to which you are entitled or from exercising your ERISA rights.

- If all or part of a claim for benefits is denied, you must be provided a written explanation of the reasons for the denial. You have the right to request that the Plan Administrator review and reconsider the denied claim.

How to Enforce Your Rights

You may take the following steps to enforce your ERISA rights. If you have any questions about this ERISA statement or about your rights under ERISA, please contact the Plan Administrator or the U.S. Department of Labor.

If you request materials and don't receive them within 30 days, you may file suit in a federal court. Unless the delay was beyond the Plan Administrator's control, the court may require the Plan Administrator to provide the materials and to pay you up to $110 per day until you receive them.

If all or part of a claim for benefits is denied or ignored, you may file suit in a state or federal court.

If the Plan fiduciaries misuse money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If your suit is successful, the court may order the person you have sued to pay these costs and fees. On the other hand, if you lose, the court may order you to pay them (if, for example, the court finds your claim to have been frivolous).

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

The Philadelphia Regional Office of the PWBA is located at: The Curtis Center, Suite 870 West, 170 S. Independence Mall West, Philadelphia, PA 19106-3317, Phone: (215) 861-5300.

ERISA Claim Fiduciary

For the purposes of ERISA, Aetna is the fiduciary with complete authority to review all denied claims for benefits under this program. This includes, hut is not limited to, the denial of certification of the medical necessity of hospital or medical treatment.

In exercising such fiduciary responsibility, American Water Works Retirement Committee shall have discretionary authority to determine whether and to what extent employees and beneficiaries are entitled to benefits, and to interpret any disputed or doubtful terms of American Water Works Medical Benefits Plan. American Water Works Retirement Committee shall be deemed to have properly exercised such authority unless it acts arbitrarily or capriciously.

The Company expects to continue this Plan, but reserves the right to amend it, or terminate it, at any time, in whole or in part. The authority to make any such changes to the Plan generally rests with the Board of Directors of American Water Works, although the Plan Administrator may also change the Plan as required by law or in a manner which will not result in a material cost. Some of the employees who participate in this Plan do so under the terms of collective bargaining agreements. The Company takes its obligations under those agreements very seriously and will, as required either by

the Company's contractual agreements or by law, negotiate changes to the Plan affecting union members with those unions whose members participate in the Plan.

Plan Benefits

These benefits are provided by American Water Works. The Managed Choice, HMO Elect Choice, Out-of-Area Comprehensive Medical, Dental, Prescription Dmg, and Short Term Disability Plans are self-insured benefits that are paid for directly by American Water Works. Aetna provides certain administrative services for the Managed Choice and Flexible Spending Account Plans. Aetna administers the Prescription Dmg Program.

American Water Works and Aetna reserve the right to interpret all Plan provisions as necessary and to make all determinations regarding benefits payable under these American Water Works Employee Benefit Plans.

Plan Documents

In preparing this Summary Plan Description, American Water Works has attempted to avoid complex language and legal terms whenever possible. If a question should ever arise concerning the nature and extent of benefits under any aspect of American Water Works Medical Benefits Plan, the actual legal Plan documents and not this Summary Plan Description, will govern.

Continuation of American Water Works Employee Benefit Plans

Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), As amended

COBRA requires that most employers who sponsor group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan would otherwise end. This is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the new law. Both you and your spouse should take the time to *read* this *carefully*.

An employee, the employee's spouse or dependent (including a child who is bom to the covered employee, or who is placed for adoption with the covered employee, during a period of COBRA continuation coverage) become Qualified Beneficiaries if the employee, the employee's spouse or dependent are covered under the employer's group health plan and would lose coverage upon the happening of one of the following events (called a Qualifying Event):

- Death of the covered employee;
- Termination (for reasons other than gross misconduct) or reduction of hours of the covered employee's employment;
- Divorce or legal separation of the covered employee from his or her spouse;
- Entitlement of the covered employee for Medicare; or
- Dependent ceases to be a "dependent child under the group health plan.

In such a case, each Qualified Beneficiary would have the right to elect to choose continuation coverage if the group health coverage would be lost. You, your spouse or your dependent children (where applicable) would each, as a Qualified Beneficiary, have the option to elect continuation coverage for a period shown as follows:

REASON FOR TERMINATION OF GROUP HEALTH COVERAGE	PERIOD
Voluntary Termination of Employee	18 months
Involuntary Termination of Employee (except for gross misconduct)	18 months
Reduction in Work Hours of Employee	18 months
Disability of Employee as determined under the Social Security Act	29 months
Death of Employee (cost paid by Company for 18 months)	36 months
Divorce or Legal Separation	36 months
Employee becomes entitled to Medicare	36 months
Dependent Child no longer qualifies as dependent under group health plan	36 months

Special Rule for Multiple Qualifying Events

If you elect continuation coverage following a termination of employment or reduction in hours and, during the 18-month period of continuation coverage, a second event (other than a bankruptcy proceeding) occurs that would have caused you to lose coverage under the plan (if you had not lost coverage already), you may be given the opportunity to extend the period of continuation coverage to a total of 36 months. If you elected continuation coverage as the spouse or dependent of a covered employee who experienced a termination of employment or reduction in hours, and during the continuation period the employee or former employee becomes entitled to Medicare, you may be given the opportunity to extend coverage for 36 months from the date the covered employee becomes entitled to Medicare.

The retiree, spouse of dependent of a retiree whose employer's group health plan is lost or substantially eliminated within one year before or after the employer's filing of a Title 11 Bankruptcy filing can elect to remain in the employer's group health plan until the retiree's death. After the retiree's death, the retiree's survivors can obtain up to an additional three years of continuation coverage.

Newly acquired dependents of Qualified Beneficiaries such as children and spouses are to be given the same opportunity to obtain coverage as for an employee with, and under the same conditions as, such dependent's coverage. The newly acquired dependent's coverage is not as a Qualified Beneficiary, and as such, their continuation coverage will end upon termination of the Qualified Beneficiary's continuation coverage.

Special Rules for Retirees and Newly Acquired Dependents

The continuation coverage will not be conditioned on a physical examination or other evidence of insurability, and will be identical. with very few exceptions, to the coverage provided to similarly situated employees or family members. ***Please note that you may be required to pay all or part of the premium for this continued coverage and an administrative fee.***

Under COBRA, your employer generally must notify the Plan Administrator (except where your employer is the Plan Administrator) within 30 days of an employee's death, termination of employment or reduction in work hours, Medicare entitlement or bankruptcy proceedings. In these cases, the Plan Administrator must then notify the Qualified Beneficiary of his or her right to elect continuation coverage. This notice must be provided within 14 days after the Plan Administrator receives notice that one of these events has occurred. However, with respect to multiemployer plans, to the extent the plan so provides, the employer may have an extended period of time for notifying the Plan Administrator of one of the qualifying events, and the Plan Administrator also may have an extended period for providing notice to the Qualified Beneficiary.

In all other cases, the employee or family member has the responsibility to notify the Plan Administrator of a divorce, legal separation, a child loses dependent status, disability as determined under the Social Security Act or a newly acquired dependent under the group health plan. In these cases, you have 60 days from the date that you would lose coverage because of one of the events described previously or the date of the qualifying event, whichever is later, to notify the Plan Administrator of the Qualifying Event. In all cases, you have 60 days from the date of the notice from the Plan Administrator or from the date you would lose coverage (whichever is later) to inform the Plan Administrator that you want continuation coverage. Your election of continuation coverage is deemed to include an election for your family members who would also lose coverage under the group health plan unless otherwise specified.

The continuation coverage extends from the date of one of the events described previously to:

- 18 months (in the case of termination or reduced work hours) or 29 months (in the case of disability) or 36 months (in all other cases described previously except retirees and newly acquired dependents.

  Beginning January 1, 1997, the disability extension will also apply if the individual becomes disabled at any time during the first ***60*** days of COBRA continuation coverage. If the individual entitled to the disability extension has nondisabled family members who are entitled to COBRA continuation coverage, those nondisabled

family members are also entitled to the 29 month disability extension.

- The date your employer no longer provides any group health plan to its employees.
- The premium for your continuation coverage is not paid on time.
- The person whose coverage is being continued becomes covered under another group health plan unless the other plan contains an exclusion or limitation with respect to a pre-existing condition. If a group health plan limits or excludes benefits for preexisting conditions but because of the new rules (beginning on or after July 1, 1997) those limits or exclusions would not apply to (or would be satisfied by) an individual receiving COBRA continuation coverage, then the plan providing the COBRA continuation coverage can stop making the COBRA continuation coverage available.
- The person whose coverage is being continued becomes entitled to Medicare benefits (unless the qualifying event is the employer's Title 11 Bankruptcy).
- You were divorced from a covered employee, subsequently remarry and become covered under another group health plan in which case you can continue until the maximum allowed period of termination of upon being covered for pre-existing conditions if new plan excludes or limits benefits for the pre-existing condition and the continuation coverage plan covers it, whichever occurs first.

To prevent a lapse in coverage, if you elect continuation coverage, you can pay any required premium within 45 days after the election.

If you employer's group health plan provides a conversion privilege to other beneficiaries, your employer must also provide you and your family members with the opportunity to enroll under a conversion health plan during the 180-day period preceding the date that continuation coverage expires.

Conversion

If any coverage being continued under this section terminates because the end of the maximum period of continuation has been reached, any Conversion Privilege will be available at the end of such period on the same terms as are applicable upon termination of employment or upon ceasing to be in an Eligible Class.

Complete details of the federal continuation provisions may be obtained from your Human Resources representative.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by the Family and Medical Leave Act of 1993 (FMLA). If American Water Works grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and American Water Works.

If American Water Works grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue health expense benefits for you and your eligible dependents. American Water Works may also allow you to continue other coverage
for which you are covered under the group contract on the day before the approved FMLA leave starts.

At the time you request the leave, you must agree to make any contributions required by American Water Works to continue coverage. American Water Works will continue to make premium payments.

If any coverage you are allowed to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date American Water Works determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your Eligible Class. However, coverage for health expenses will be available to you under another plan sponsored by American Water Works.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by American Water Works, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce, or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date American Water Works determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for American Water Works following the date American Water Works determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave, provided you make request for such coverage within 31 days of the date American Water Works determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because American Water Works determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date American Water Works determines the approved FMLA leave is terminated.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health insurance coverage for workers and their families when they change or lose their jobs.

Special Enrollment Rights

Late Enrollee

A "Late Enrollee" is a person (including yourself) for whom you do not elect Health Expense Coverage within 31 days of the date the person becomes eligible for such coverage.

Enrollment Procedure

You may elect coverage for a Late Enrollee only during the annual late entrant enrollment period established by your Employer.

Coverage for a Late Enrollee will become effective on the first day of the second calendar month following the end of the late entrant enrollment period during which you elect coverage for the Late Enrollee.

Exceptions

A person will not be considered to be a Late Enrollee if all of the following are met:

- you did not elect Health Expense Coverage for the person involved within 31 days of the date you were first eligible (or during an open enrollment) because at that time:

  the person was covered under other "creditable coverage" as defined below: and

  you stated, in writing, at the time you submitted the refusal that the reason for the refusal was because the person had such coverage; and

- the person loses such coverage because:

  of termination of employment in a class eligible for such coverage;

  of reduction in hours of employment;

your spouse dies;

you and your spouse divorce or are legally separated;

such coverage was COBRA continuation and such continuation was exhausted; or

the other plan terminates due to the employer's failure to pay the premium or for any other reason; and

you elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

As used above, "creditable coverage" is a person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such coverage includes coverage issued on a group or individual basis; Medicare; Medicaid; military-sponsored health care; a program of the Indian Health Service; a state health benefits risk pool; the Federal Employees' Health Benefit Plan (FEHBP); a public health plan as defined in the regulations; and any health benefit plan under Section 5(e) of the Peace Corps Act.

If you are not considered a Late Enrollee, Health Expense Coverage will become effective on the date of the election.

Additional Exceptions

Also, a person will not be considered a Late Enrollee if you did not elect, when the person was first eligible, Health Expense Coverage for:

- A spouse or child who meets the definition of a dependent, but you elect it later and within 31 days of a court order requiring you to provide such coverage for your dependent spouse or child. Such coverage will become effective on the date of the court order.

  Yourself, and you subsequently acquire a dependent, who meets the definition of a dependent, through marriage, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the election.

- Yourself. and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable.
- Yourself and your spouse, and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect

coverage for yourself, your spouse, and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable.

Certificate of Creditable Coverage

Your Right to Receive a Certificate of Health Coverage

When you or your covered dependents terminate coverage under the Plan, a certification of coverage form will be issued to you specifying your coverage dates under the health plan and any probationary periods you were required to satisfy. The certification of coverage form will contain all the necessary information another health plan will need to determine if you have prior continuous coverage that should be credited toward any preexisting condition limitation period. Health plans will require that you submit a copy of this form when you apply for coverage.

The certification of coverage form will be issued to you when you terminate coverage with the group and, if applicable, at the expiration of any continuation period. The Claims Administrator will also issue the certification of coverage form if you request an additional copy at any time within the 24 months after your coverage terminates.

Glossary

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

Room and Board Charges

Charges made by an institution for board and room and other necessary services and supplies. They must be made regularly at a daily or weekly rate.

Convalescent Facility

This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from illness or injury:
  - professional nursing care by an R.N., or by an L.P.N. directed by a full-time R.N., and
  - physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24-hour-a-day nursing care by licensed nurses directed by a full-time R.N.
- Is supervised full-time by a physician or R.N.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mentally retarded persons, for custodial or educational care, or for care of mental disorders.
- Makes charges for services rendered.

Copay

This is a fee charged to a person for Covered Medical Expenses, as specified in the applicable Summary of Coverage.

Course of Treatment

This is a planned program of services or supplies furnished by a health care provider.

The program must be:

- In connection with the diagnosis and treatment of an injury or illness,

- Of definite duration, and
- Approved by the Primary Care Physician, for Managed Choice participants.

Custodial Care

This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- By whom they are prescribed, or
- By whom they are recommended, or
- By whom they are performed.

Dentist

This means a legally qualified dentist. Also, a physician who is licensed to do the dental work he or she performs.

Directory

This is a listing of Preferred Care Providers in the Service Area covered under this Plan, which is given to American Water Works for distribution to all employees covered under the Managed Choice Plan.

Disciosure of Information to Others

(This applies only to the Out-of-Area Comprehensive Medical Plan. the Out-of-Area Comprehensive Dental Plan, and the Life Insurance Benefits Plans.)

All information will be treated as confidential. It will not be disclosed to others without your authorization, except in some instances where such disclosure is necessary for the conduct of Aetna's business. Disclosure cannot be contrary to any law which applies.

The following sets forth the types of disclosure that may be made:

- Information may be made available to American Water Works or his or her representative in connection with the claim and financial administration of the Plan. This includes policyholder audits.
- Information may be disclosed to other insurers if there may be duplicate coverage or a need to preserve the continuity of your coverage.
- Information may be disclosed to Peer Review Organizations and other agencies to determine whether health services were necessary and reasonably priced.

In addition, information may be given to regulators of Aetna's business and to others as may be required by law. It may also be given to law enforcement authorities when needed to prevent or prosecute fraud or other illegal activities.

Emergency Care

The first care given in a hospital's emergency room after a sudden and. at the time, unexpected change in a person's physical or mental condition such that:

- Care cannot safely and adequately be provided other than in a hospital, or
- Adequate care is not available at the time and place it is needed.

Emergency Condition

This means the sudden and, at that time, unexpected onset of a change in a person's physical or mental condition which, if the procedure or treatment were not performed right away could, as determined by Aetna, reasonably be expected to result in:

- Loss of life or limb, or
- Significant impairment to bodily function, or
- Permanent dysfunction of a body part,

Home Health Care Agency

This is an agency that:

- Mainly provides skilled nursing and other therapeutic services,
- Is associated with a professional group which makes policy (this group must have at least one physician and one R.N.),
- Has full-time supervision by a physician or an R.N.,
- Keeps complete medical records on each person,
- Has a full-time administrator, and
- Meets licensing standards.

Home Health Care Plan

This is a plan that provides for care and treatment of an illness or injury.

The care and treatment must be:

- Prescribed in writing by the attending physician, and
- An alternative to confinement in a hospital or convalescent facility.

Hospice Care

This is care given to a terminally ill person by or under arrangements with a Hospice Care Agency. The care must be part of a Hospice Care Program.

Hospice Care Agency

This is an agency or organization which:

- Has Hospice Care available 24 hours a day.

- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Provides:
  - skilled nursing services,
  - medical social services,
  - psychological and dietary counseling, and
  - bereavement counseling for the immediate family.
- Provides or arranges for other services which will include:
  - services of a physician,
  - physical or occupational therapy,
  - part-time home health aide services which mainly consist of caring for terminally ill persons, and
  - inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel which include at least:
  - one physician,
  - one R.N.,
  - one licensed or certified social worker employed by the Agency, and
  - one pastoral or other counselor.
- Establishes policies governing the provision of Hospice Care.
- Assesses the patient's medical and social needs.
- Develops a Hospice Care Program to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by physicians, other than those who own or direct the Agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Utilizes volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program

This is a written plan of Hospice Care, which:

- Is established by and reviewed from time to time by:
  - a physician attending the person, and
  - appropriate personnel of a Hospice Care Agency.
- Is designed to provide palliative and supportive care to terminally ill persons, and supportive care to their families.
- Includes an assessment of the person's medical and social needs, and a description of the care to be given to meet those needs.

Hospice Facility

This is a facility, or a distinct part of one, which:

- Mainly provides inpatient Hospice Care to terminally ill persons.
- Charges its patients.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program; this includes reviews by physicians other than those who own or direct the facility.
- Is run by a staff of physicians; at least one such physician must be on call at all times.
- Provides, 24 hours a day, nursing services under the direction of an R.N.
- Has a full-time administrator.

Hospital

This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of physicians.
- Provides 24-hour-a-day R.N. service.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Makes charges for services rendered.

Information That May Be Collected

(This applies only to the Out-of-Area Comprehensive Medical Plan, the Out-of-Area Comprehensive Dental Plan, and the Life Insurance Benefits Plans)

Aetna, in providing insurance services to you, relies mainly on the information you give on your group enrollment form and when you file claims.

Aetna may also collect information about you from other sources. This is information necessary for Aetna to perform its function with regard to the insurance transaction in question. For example, if the amount or type of coverage you are entitled to depends on your earnings or job class, Aetna would obtain that information from American Water Works.

L.P.N.

This means a licensed practical nurse.

Mental Disorder

This is an illness commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist, or a psychiatric social worker. **A** mental or nervous disorder includes, but is not limited to:

- Alcoholism and drug abuse.
- Schizophrenia
- Bipolar disorder
- Pervasive mental developmental disorder (Autism).
- Panic disorder.
- Major depressive disorder.
- Psychotic depression.
- Obsessive compulsive disorder.

Mental disorder will not include alcoholism and drug abuse if a separate benefit applies to treatment of alcoholism and drug abuse.

Necessary

A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, care, or treatment of the illness or injury involved.

To be appropriate, the service or supply must:

- Be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the illness or injury involved and the person's overall health condition,
- Be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both **as** to the illness or injury involved and the person's overall health condition, and

- As to diagnosis, care, and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply that meets the above tests.

In determining whether a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- Information provided on the affected person's health status,
- Reports in peer reviewed medical literature,
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data,
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment,
- The opinion of health professionals in the generally recognized health specialty involved, and
- Any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be necessary:

- Those that do not require the technical skills of a medical, mental health, or dental professional,
- Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any health care provider or health care facility,
- Those furnished solely because the person is an inpatient on any day on which the person's illness or injury could safely and adequately be diagnosed or treated while not confined, or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Negotiated Charge

This is the maximum charge a Preferred Care Provider has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

Non-Occupational Illness

A non-occupational illness is an illness that does not:

- arise out of (or in the course of) any work for pay or profit, or
- result in any way from an illness that does.

An illness will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- is covered under any type of Workers' Compensation law, and
- is not covered for that illness under such law

Nan-Occupational Injury

A non-occupational injury is an accidental bodily injury that does not

- Arise out of (or in the course of) any work for pay or profit, or
- Result in any way from an injury, which does.

Non-Preferred Care

This is a health care service or supply furnished by a health care provider that is not Preferred Care.

Nan-Preferred Care Provider

This is a provider who is:

- A health care provider that has not contracted to fumish services or supplies at a Negotiated Charge, or
- A Preferred Care Provider that is furnishing services or supplies without the referral of a Primary Care Physician.

Orthodontic Treatment

This is any:

- Medical service or supply, or
- Dental service or supply, furnished to prevent or to diagnose or to correct a misalignment:
- Of the teeth, or
- Of the bite, or
- Of the jaws or jaw joint relationship, whether or not for the purpose of relieving pain.

Not included is:

- The installation of a space maintainer, or
- A surgical procedure to correct malocclusion.

Physician

This means a legally qualified physician.

Preferred Care

This is a health care service or supply furnished by:

- A person's Primary Care Physician, or a Preferred Care Provider on the referral of the Primary Care Physician.
- A Non-Preferred Care Provider on the referral of the person's Primary Care Physician and if approved by Aetna.

Any health care provider for an emergency condition when travel to a Preferred Care Provider or referral by a person's Primary Care Physician prior to treatment is not feasible.

Preferred Care Provider

This is a health care provider that has contracted to furnish services or supplies for a Negotiated Charge, but only if the provider is, with Aetna's consent, included in the Directory as a Preferred Care Provider for:

The service or supply involved, and

The class of employees of which you are member.

Primary Care Physician

This is the Preferred Care Provider who is:

Selected by a person from the Aetna website at www.aetna.com.
Responsible for the person's on-going health care, and

Shown on Aetna's records as the person's Primary Care Physician.

Privacy Notice Regarding Insured Plans Underwritten by Aetna

Aetna has adopted a comprehensive insurance privacy policy based on the recommendations of the Federal Privacy Protection Study Commission. This Notice describes certain aspects of that policy, which apply to you as a covered person in a plan of group insurance insured by Aetna. The policy does not apply where a different approach is required by law.

Reasonable and Customary Charge

Only that part of a charge, which is reasonable, is covered. The reasonable charge for a service or supply is the lower of:

The provider's usual charge for furnishing it, or

The charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In determining the reasonable charge for a service or supply that is:

Unusual,

Not often provided in the area, or

Provided by only a small number of providers in the area,

Aetna may take into account such factors as:

- The complexity of the service or supply,

The degree of skill needed,

The type of specialty of the provider,

The range of services or supplies provided by a facility, and

The prevailing charge in other areas.

Right of Access and Correction

(This applies only to the Out-of-Area Comprehensive Medical Plan, the Out-of-Area Comprehensive Dental Plan, and the Life Insurance Benefits Plans)

In general, you have a right to learn the nature and substance of any information Aetna has in its files about you. You may also have a right of access to such files, except information, which relates to a claim or a civil or criminal proceeding, and to ask for correction, amendment, or deletion of personal information. This can be done in states which provide such rights and which grant immunity to insurers providing such access. If you request any health information, Aetna may elect to disclose details of the information you request to your (attending) physician. If you wish to exercise this right or if you wish to have more details on our information practices, please contact:

Aetna
Benefit Contracts Compliance, MB58
151 Farmington Avenue
Hartford, CT 06156

R.N.

This means a registered nurse.

Semi-Private Rate

This is the charge for board and room, which an institution applies - to the most beds in its semi-private rooms with two or more beds. If there are no such rooms, Aetna will figure the rate. It will be the -rate most commonly charged by similar institutions in the same geographic area.

Service Area

This is the geographic area in which Preferred Care Providers for this Plan are located, as determined by Aetna.

Terminally Ill

This is a medical prognosis of six months or less to live.

Totally Disabled

The words "totally disabled" mean that because of injury or illness:

- You are not able to engage in your customary occupation and are not working for pay or profit.
- Your dependent is not able to engage in most of the normal activities of a person of like age and sex in good health.

Termination of Coverage

Coverage under this Plan terminates when the first of these - events happen:

- The day your employment ceases.
- When the group contract terminates as to the coverage
- When you are no longer in an Eligible Class

When you fail to make any required contribution.

Ceasing active work will be deemed to be cessation of employment. However, if you are not at work because of illness or injury, your employment will be continued for up to six months from the start of the absence. It may be further continued, until stopped by your Employer, but not beyond 12 months from the start of the absence.

If this provision applies to you or one of your covered dependents, see the section Continuation of Coverage Under Federal Law – COBRA for information which may affect you.

General Information

Plan Sponsor
American Water Works Company, Inc. and its Designated Subsidiaries
1025 Laurel Oak Road
Voorhees, NJ 08043

Employer Identification Number
51-0063696

Plan Number
501

Effective Date
October 1, 1996

Plan Year End
December 31

Plan Administrator
Vice President, Human Resources
American Water Works Company, Inc.
1025 Laurel Oak Road
Voorhees, NJ 08043

Agent for Service of Legal Process
The Secretary
American Water Works Company, Inc.
1025 Laurel Oak Road
Voorhees, NJ 08043

Funding
Self-insured

The Newborns' and Mothers' Health Protection Act of 1996
The Plan does not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

The attending provider, after consulting with the mother, may discharge the mother and newborn earlier than 48 hours following a vaginal delivery or 96 hours following a caesarean section.

Women's Health and Cancer Rights Act of 1998
This Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas.