KENTUCKY-AMERICAN WATER COMPANY
CASE NO. 2008-00427
PUBLIC SERVICE COMMISSION'S FIRST SET OF INFORMATION REQUESTS
ITEMS 1 – 33

Witness Responsible:

Michael A. Miller

21. Provide a complete copy of each group medical insurance policy that Kentucky-American currently maintains for its employees.

Response:

Please find attached the American Water Group Insurance Plan Summaries.

For the electronic version, please refer to the following documents:
KAW_R_PSCDR1#21_PART1_111408.pdf
KAW_R_PSCDR1#21_PART2_111408.pdf
KAW_R_PSCDR1#21_PART3_111408.pdf

American Water Group Insurance Plan Summary Plan Description For Non-Union Employees

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Glossary

The Plan described in this booklet is based on plan documents and contracts that govern its operation. Because this booklet is a summary only, it does not describe all of the provisions of the Plan and the possible fact situations that may occur. If a conflict arises between this summary and any official plan documents, the official plan documents will govern.

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Introduction

Just as American Water provides a comprehensive range of products and services which can be tailored for our customers' individual needs, we provide a flexible, comprehensive benefits package which allows our employees to select the benefits that best meet their needs.

This Summary Plan Description ("SPD") of the Group Insurance Plan of American Water Works Co., Inc. and Its Designated Subsidiaries and Affiliates (the "Plan") supplements the booklets and certificates provided by the various insurance carriers and provides a general description, written in non-technical language, of the important provisions of the Plan. There may be other materials (such as an insurance policy or other contractual agreement with a health care or other service provider) that contain more detailed information about Plan benefits. Every effort has been made to ensure that all of these materials contain a consistent description of the Plan's benefits. However, if there is any conflict or inconsistency between these materials, it is the Plan Administrator's responsibility to interpret the conflicting provisions and determine what benefits will be provided under the Plan.

American Water provides this SPD to comply with certain laws and to give you the information you need to use your benefits. Nothing in this booklet is meant to interpret, extend, or change in any way the provisions of this Plan. No one speaking on behalf of the Plan or the Company can alter the terms of the Plan.

About This Booklet

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

Please read this Summary Plan Description carefully and refer to it whenever you have questions about the American Water benefits program or the specific coverages that apply to you. If you have questions about these plans, please contact the Benefits Service Center at (866) 888-8269 or email Benefits_Service_Center@amwater.com.

American Water reserves the right to amend the benefit plans described in this summary at any time, without prior notice to participants, including the right to change eligibility criteria or program costs and the right to restrict or eliminate benefits provided.

American Water also reserves the right to terminate or discontinue these benefits any time, without prior notice to employees.

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.

The Benefit Programs

Your American Water benefits have been designed to reward your commitment to provide excellent service and drive business performance. It can add up to a significant part of your total compensation, giving you added security and peace of mind.

This SPD describes the following employee benefit programs:

- Medical

  (Standard and Premium PPOs, EPO, and Opt Out of Coverage)
- Prescription Drug
- Vision
- Dental
- Flexible Spending Accounts

  (Health Care and Dependent Care)
- Disability

  (Sick Days, STD, and LTD)
- Life Insurance

  (Basic, AD&D, Supplemental, Spouse and Dependent, and Travel Accident)
- Employee Assistance Program

Eligibility

You and your dependents are eligible to participate in the benefits described in this Summary Plan Description if you are an American Water non-bargaining employee and you are a full-time employee (working not less than 35 hours each week).

You are ineligible to participate in the Plan if you (1) are a part-time employee (working less than 35 hours each week), (2) are classified as a temporary employee in accordance with the Company's personnel policies and practices, (3) are an employee covered by a collective bargaining unit, (4) perform services for the Company pursuant to an arrangement with a leasing organization or any other third-party, including but not limited to a "leased employee" within the meaning of section 414(n) of the Code, or (5) person who is classified as an independent contractor or otherwise as a person who is not treated as an employee for purposes of withholding federal employment taxes, regardless of any contrary governmental or judicial determination relating to such employment status or tax withholding obligation. If a person described in the preceding sentence is subsequently reclassified as, or determined to be, an employee by the Internal Revenue Service, any other governmental agency or authority, or a court, or if the Company is required to reclassify such an individual as an employee as a result of such reclassification or determination (including any reclassification by the Company in settlement of any claim or action relating to such individual's employment status), such individual shall not become eligible to become a participant in the Plan by reason of such reclassification or determination.

Your eligibility and participation date is the first day of the month after you complete one full month of continuous service with the Company. **Example**: If your start date is January 21, your Benefits Eligibility Date is March 1. 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 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 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 (attending high school or attending an accredited learning institution with at least 12 credits)
  - 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

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

Health Plan Coverage for Handicapped Dependent Children

Health Plan 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.

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 unable to earn his or her own living because of mental retardation or a physical handicap which started before 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 Horizon 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 proof that 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.

Horizon will have the right to require proof of the continuation of the handicap. Horizon 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.

An Overview of Your Options

Eligible employees and their dependents may participate in the Standard Preferred Provider Organization (Standard PPO) Plan, the Premium Preferred Provider Organization (Premium PPO) Plan, or the Exclusive Provider Organization (EPO) Plan.

The PPO Plans emphasize both preventive care and protection against the cost of illness and serious injury.

Horizon Blue Cross Blue Shield (Horizon) provides the PPO and EPO plans. Horizon has negotiated special rates with in-network health care providers in the plans to offer you competitive health care. To locate participating network providers, call (800) 810-BLUE (2583) or use the Provider Finder at www.horizonblue.com/nationalaccounts.

Note: Eligible Hawaii employees and their dependents may participate in the HMSA Medical Plan. The Horizon Plans do not

apply to Hawaii employees. HMSA is part of the American Water Group Health Plan.

Standard PPO Plan and Premium PPO Plan

With the Standard PPO and the Premium PPO, you have a choice to make each time you use the plan: whether to receive care from a doctor, hospital, or health care provider that is part of the plan's network, or from any provider outside the network. You will receive a higher level of coverage (i.e., the plan will pay a higher percentage of the cost of service) when you receive care through the network and your out-of-pocket costs will be lower compared to receiving care outside of the network.

You do not have to select a primary care doctor to coordinate your care (e.g., when you need specialty services). However, it is always a good idea to maintain a relationship with a doctor who knows you and your medical history and who can help you make the right choices about your care.

What's the Difference?

The Standard PPO and the Premium PPO operate identically. The Standard PPO and Premium PPO differ by the deductible and coinsurance amounts, and by the amounts you pay out of your paycheck for coverage. Detailed descriptions of these plans begin on page 16.

Exclusive Provider Organization (EPO)

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

In contrast to the PPO plans, the EPO plan offers **no** out-of-network benefits. What does that mean? In order to receive plan benefits, you must receive care from a doctor, hospital, or health care provider that is part of the plan's network. The EPO includes comprehensive benefits -- you pay a copay and then the plan covers 100% of the remaining costs -- so at the time of service, you pay a set, flat amount.

Similar to the PPO, you do not have to select a primary care doctor to coordinate your care (for example, when you need specialty services).

Hawaii

Your medical plan will continue to be administered by HMSA. Please contact the Benefits Service Center for information.

Listings of Network Providers

To locate providers that participate in the Horizon network, you can call (800) 810-BLUE (2583) or use the *Provider Finder* at www.horizonblue.com/nationalaccounts.

Medical Opt-Out of Coverage

The medical opt-out provisions give you the opportunity not to elect medical coverage.

You have two options for opting out of coverage:

- You may choose not to enroll in medical coverage and receive only dental/vision coverage.
- Dental/vision coverages are bundled and you can elect to purchase this coverage even if you do not enroll in medical. If you elect to receive dental/vision coverage only, you will receive premium dental and your monthly contributions will be deducted from your paycheck on a pre-tax basis.
- You may choose not to enroll in any medical, dental or vision plans at all.

If you were hired before January 1, 2006, and choose to opt out of medical, dental and vision coverage for yourself and your dependents, the Company will credit you $100 per month.

Please note, to receive the cash credit:

- You must make an election not to enroll in medical/dental/vision to receive the full credit.
- 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 Change in Status that would allow you to drop your medical coverage, you must provide documentation that you have medical coverage elsewhere. A signed affidavit obtained from the Benefits Service Center can be used as proof. This is not required during open enrollment or if you are a new hire.

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

Plan Comparison Chart

Below is a comparison of benefits for the Standard PPO, the Premium PPO, and the EPO.

Horizon Medical Plans					
Plan Feature	**Standard PPO**		**Premium PPO**		**EPO**
	In-network	*Out-of-network*	*In-network*	*Out-of-network*	*In-network benefits only*
Deductible (single/family)	$1,000/$3,000	$1,500/$4,500	None	$200/$600	None
Coinsurance	80%	60%	90%	70%	100%
Out-of-pocket maximum (single/family)	$3,500/$10,500	$4,000/$12,000	$1,000/$3,000	$3,000 per person	None
Lifetime maximum benefit	Unlimited		Unlimited		Unlimited
Preventive Care					
Routine physical exam	100% (up to $250 per 24 months), well baby to 6 yrs	Not Covered	100% after $15 copay (one every 24 months), well baby to 6 yrs	Not Covered	100% after $15 copay
Immunizations	100%	Not Covered	100% after $15 copay	Not Covered	100% after $15 copay
Routine hearing exam	100% (one every 24 months)	Not Covered	100% after $15 copay	Not Covered	100% after $15 copay
Routine OB/GYN exam	100% (one per calendar year)	Not Covered	100% after $15 copay (one per calendar year)	Not Covered	100% after $15 copay
Mammography	100% (one baseline between age 35-39, annual screening age 40 and above)	Not Covered	100% after $15 copay (one baseline between age 35-39, annual screening age 40 and above)	Not Covered	100% (one baseline between age 35-39, annual screening age 40 and above)
Doctor and Hospital Services					
Office visits (primary care and specialist)	80% after deductible	60% after deductible	100% after $15 copay	70% after deductible	100% after $15 copay
Allergy testing and treatment centers	80% after deductible	60% after deductible	100% after $15 copay	70% after deductible	100%

Horizon Medical Plans					
Plan Feature	**Standard PPO**		**Premium PPO**		**EPO**
	In-network	*Out-of-network*	*In-network*	*Out-of-network*	*In-network benefits only*
Diagnostic x-ray and lab	80% after deductible	60% after deductible	Independent Lab: 100% Doctor's Office: 100% after $15 copay	70% after deductible	100%
Hospital inpatient services	80% after deductible	60% after deductible	90%	70% after deductible and $250 copay per admit	100% after $100 copay per admit
Outpatient surgery	80% after deductible	60% after deductible	100%	70% after deductible	100%
Outpatient preadmission testing	80% after deductible	60% after deductible	100%	70% after deductible	100%
Ambulance (if medically necessary)	80% after deductible	80% after deductible	90%	90%	100%
Emergency room	80% after deductible	60% after deductible	100% after $25 copay (waived if admitted)	100% after $25 copay (waived if admitted)	100% after $35 copay (waived if admitted)
Hospital Alternatives					
Home health care	80% after deductible (120-visit maximum per calendar year)	60% after deductible (120-visit maximum per calendar year)	90% (120-visit maximum per calendar year)	70% after deductible (120-visit maximum per calendar year)	100%
Private duty nursing	80% after deductible (70-shift maximum per calendar year)	80% after deductible (70-shift maximum per calendar year)	90% (70-shift maximum per calendar year)	90% after deductible (70-shift maximum per calendar year)	100%
Skilled nursing facility	80% after deductible (120-day maximum)	60% after deductible (120-day maximum)	90% (120-day maximum)	70% after deductible (120-day maximum)	100% (100-day maximum per calendar year)
Hospice inpatient	80% after deductible (90-day lifetime maximum)	60% after deductible (90-day lifetime maximum)	90% (90-day lifetime maximum)	70% after deductible (90-day lifetime maximum)	100%
Hospice outpatient	80% after deductible ($5,000 lifetime maximum)	60% after deductible ($5,000 lifetime maximum)	90% ($5,000 lifetime maximum)	70% after deductible ($5,000 lifetime maximum)	100%
Durable medical equipment	80% after deductible	80% after deductible	90%	90%	100%

Horizon Medical Plans					
Plan Feature	**Standard PPO**		**Premium PPO**		**EPO**
	In-network	*Out-of-network*	*In-network*	*Out-of-network*	*In-network benefits only*
Short-term rehabilitation (for acute conditions only)	80% after deductible (60-day maximum per calendar year)	60% after deductible (60-day maximum per calendar year)	90% (60-day maximum per calendar year)	70% after deductible (60-day maximum per calendar year)	100% (60-day maximum per calendar year)
Mental Health and Chemical Dependency					
Inpatient treatment of mental/nervous conditions	80% after deductible (45-day maximum per calendar year)	60% after deductible (45-day maximum per calendar year)	90% (45-day maximum per calendar year)	70% after deductible (45-day maximum per calendar year), $250 copay per confinement	100% (30-day maximum per calendar year)
Outpatient treatment of mental/nervous conditions	80% after deductible (20-visit maximum per calendar year)	50% after deductible (20-visit maximum per calendar year)	100% after $20 copay (20-visit maximum per calendar year)	50% after deductible (20-visit maximum per calendar year)	100% after $25 copay (20-visit maximum per calendar year)
Inpatient alcohol/drug treatment	80% after deductible (45-day maximum per calendar year, 2 courses of treatment per lifetime)	60% after deductible (45-day maximum per calendar year, 2 courses of treatment per lifetime)	90% (45-day maximum per calendar year, 2 courses of treatment per lifetime)	70% after deductible (45-day maximum per calendar year, 2 courses of treatment per lifetime), $250 copay/ confinement	100% (30-day maximum per calendar year; 90-day lifetime)
Outpatient alcohol/drug treatment	80% after deductible (20-visit maximum per calendar year)	50% after deductible (20-visit maximum per calendar year)	100% after $20 copay (20-visit maximum per calendar year)	50% after deductible (20-visit maximum per calendar year)	100% for first treatment; the lesser of $25 copay or 50% covered second and subsequent treatment courses (60-visit maximum per calendar year; 120-visit lifetime maximum)

Horizon Medical Plans					
Plan Feature	**Standard PPO**		**Premium PPO**		**EPO**
	In-network	*Out-of-network*	*In-network*	*Out-of-network*	*In-network benefits only*
Prescription drugs (participant coinsurance or copay)					
Retail: • Generic • Preferred brand • Non-preferred brand	10% 20% 20%		10% 20% 20%		10% 20% 20%
Mail order: • Generic • Preferred brand • Non-preferred brand	$14 copay $30 copay $70 copay		$14 copay $30 copay $70 copay		$14 copay $30 copay $70 copay

This chart is only a highlight of the medical option features, and certain limits may apply to some features. Out of network benefits may be subject to Reasonable and Customary (R&C) limits and you may be responsible for non-network provider charges in excess of R&C limits in addition to a coinsurance. All maximums are combined for mental health and chemical dependency expenses. Mental health and chemical dependency amounts *do not* apply to your out-of-pocket maximum. Official Plan documents govern in the event of any inconsistency between the provisions shown here and in the Plan documents.

Enrolling For Medical Coverage

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

The Benefits Service Center will conduct a benefits orientation with newly hired employees to review benefits and explain the enrollment process.

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

- The Standard Preferred Provider Organization Plan
- The Premium Preferred Provider Organization Plan
- The Exclusive Provider Organization Plan
- Premium Dental/Vision Only
- The Medical Opt-Out Option and Cash Credit (if applicable)

If you are newly hired eligible employee (see "Eligibility" above) and you want to enroll you and your dependent(s) in a medical plan, you must return your completed enrollment form to the Benefits Service Center before your **Benefits Eligibility Date**. Your **Benefits Eligibility Date** is the first day of the month following completion of one full month of continuous employment. **Example**: If your start date is January 21, your Benefits Eligibility Date is March 1 and your enrollment form should be returned by February 7.

Unless you are taking the Opt-Out Option, you must include the following documentation along with your enrollment form:

- a copy of your birth certificate and your dependent(s) birth certificate(s); and
- a copy of your marriage certificate, if applicable.

If you do not submit the completed form and required documentation, you will not be enrolled in Medical and Dental/Vision Plans or the Opt-Out Option, if applicable; and you will not receive the $100 opt-out credit per month, if applicable. In addition, you will not be able to enroll in a medical plan until the next Open Enrollment period unless you have a Change in Status or a Special 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.” **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 provider who is accepting new patients is set forth in the following chart, although the actual distance may be greater in some cases:

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

Changes in Status

You may enroll in a Plan as a new hire or during the annual Open Enrollment period. However, if you or your family experience a Change in Status (as described below), you may enroll or add or drop dependents during the Plan Year on account of, and consistent with, the Change in Status. **You must contact the Benefits Service Center to notify them of your Change in Status within 31 days after the change has occurred.** A new benefit form must be completed.

Note: A Change in Status does not allow you to change your current medical plan option (for example, switch from the Standard PPO to the Premium PPO) unless the change also entitles you to a special enrollment period described below.

The following events are changes in status:

- Marriage, death of spouse, divorce, legal separation, or annulment;
- A child qualifies as a dependent;
- 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;
- If your spouse’s employer holds open enrollment at a time other than American Water;
- You became disabled;
- Coverage changes, such as a change in coverage under a spouse's plan.

You can also enroll or add or drop dependents during the Plan Year 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 or a dependent become entitled (or cease to be entitled) to Medicare or Medicaid.

Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

A newborn child, an adopted child, or a child placed with you for adoption is automatically covered for the first 31 days of life, the date the child was adopted, or the date the child was placed for adoption. To continue coverage for a newborn beyond 31 days, you must enroll within 31 days of the birth. To continue coverage for an adopted child or a child placed with you for adoption beyond 31 days, you must enroll within 31 days of the adoption or placement.

In addition, if you have a new dependent as a result of marriage, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage.

To request special enrollment or obtain more information, contact the Benefits Service Center.

Note: Certain events could result in an immediate loss of eligibility for dependents: if you get divorced or legally separated; if your dependent child marries; or if your dependent child reaches age 19 (age 23, if a full-time student) or graduates from college before age 23.

The Preferred Provider Organization (PPO) Plans (Standard and Premium)

The Preferred Provider Organization Plans (Standard and Premium)

The Plans are self-insured by American Water. Horizon-Blue Shield provides certain administrative services under the Plan.

The Preferred Provider Organization (PPO) Plans are self-insured by American Water. A plan is considered to be "self-insured" when a company uses its own funds to pay claims. Horizon provides certain administrative and claim payment services under the Plans, but does not guarantee benefit payments. The PPO Plans emphasize preventive care and protects you from the cost of illness and serious injury while providing you with access to a high level of benefits.

If you want to receive the advantages of the PPO Plans, you should select a doctor within Horizon's network. As you may know, Horizon maintains a nationally recognized health care provider network. In fact, most providers and hospitals currently used by our employees are members of the Horizon network. If you cover any college-age dependents, we anticipate that they will have access to network doctors when they are away at school. To learn which doctors are in the network, call Horizon at (800) 810-BLUE (2583) or use the Provider Finder at www.horizonblue.com/nationalaccounts.

You do not have to coordinate your care through a primary care physician (PCP) to receive a high level of benefits. In addition, you do not need to obtain a referral from your PCP in order to see a specialist. However, it's a good idea to see a PCP first to make sure you are getting appropriate care.

If you obtain care from an out-of-network doctor, the Plan may pay a lower level of benefits and some services (such as preventive care services) are not covered at all.

How the Preferred Provider Organization Plans Work

With the PPO Plans, you do not need to select a PCP before you receive medical care, nor do you need to obtain referrals to see a specialist. However, when you need care, you should choose a doctor from a "network" of health care providers to receive the highest level of benefits under the Plan.

You can select a network provider from among those listed on Horizon's website at www.horizonblue.com/national accounts or by calling Horizon at (800) 810-BLUE (2583)

IF YOU CHOOSE A PROVIDER IN THE NETWORK, you receive a higher level of reimbursement for your medical expenses than you would receive if you chose a provider outside the network.

- You do not have to meet an annual deductible with the Premium PPO if you use an in-network provider (the Standard PPO *does* have an annual deductible for in-network providers).
- Your in-network healthcare providers file all your claims.
- Your in-network doctor initiates all required precertification.
- 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 Horizon has negotiated with them. (See the Glossary for a definition of "reasonable and customary charge.")

Under the PPOs, you may receive care from any provider you choose. IF THE PROVIDER IS OUTSIDE THE NETWORK:

- You will have to meet an annual deductible with both the Standard and Premium PPOs,
- 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 have to pay any expenses in excess of the "reasonable and customary charges" on which Plan payment is based, in addition to the applicable coinsurance amount.

When You Need a Specialist

If you need specialized care, you do not need a referral. Remember, in order to receive the highest level of benefits, you must use a specialist who belongs to the network.

If you need medical services or treatment that is not available within the PPO network, your doctor may recommend a specialist who does not belong to the network. In this case, your doctor must obtain

precertification from Horizon and you will receive the higher level of benefits.

Coverage for Dependents Who Live Outside the Network Area

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

The PPO options have special provisions to meet the needs of your covered dependents who live outside the network area. In general, when selecting doctors for your out-of-area children, consider these guidelines:

- If your child is away at school, you should select a doctor from the area where you live and arrange for routine care during school breaks. If your child needs medical care during the school year, he or she should visit the school infirmary and find in-network doctors or hospitals on the website. Benefits will be paid at the in-network level.

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

- 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. If you are enrolled in a PPO and a PPO network is available in that area, your child may select a doctor from the local network and receive the higher level of benefits. To locate providers in the Horizon network, call (800) 810-BLUE (2583) or use the Provider Finder at www.horizonblue.com/nationalaccounts.
- There is no coverage for Routine Physical Exams, Routine Eye Exams, and Routine Hearing Exams.

Coverage When You Are Traveling

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

You should call Horizon Member Services at (800) 355-BLUE (2583) for a list of participating doctors and hospitals to receive the highest 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 doctor. A 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 burns, 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 to seek immediate care at the nearest appropriate facility.

When a covered person is confined as a full-time inpatient as the result of an **emergency** admission, you, the person's doctor, or the hospital must call Horizon Member Services to request certification within 48 hours of the start of the confinement. If the call cannot be made 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.

Precertification

Precertification is an important feature of the PPO Plans. In order for you to receive the highest level of benefits available, **you, the network hospital, or your doctor** must notify Horizon to precertify any hospital admission 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.

If you elect to get care from an out-of-network provider you will have to initiate the precertification process yourself.

Procedures Which Must Be Precertified

Precertification is required for:

- All hospital and skilled nursing/convalescent facility admissions;
- Home health care, hospice care, and skilled nursing care;

- Inpatient treatment for substance abuse and mental disorders.

Call Horizon for all other procedures.

How to Request Precertification for a Medical Procedure or Admission

To request precertification of an admission or procedure, call the precertification telephone number listed on your ID card, or call Horizon Member Services, toll-free, at **(800) 355-BLUE (2583)** 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 precertification telephone number listed on your ID card or Horizon Member Services, toll-free, at **(800) 355-BLUE (2583)**. You should call at least 14 days before any scheduled admission or outpatient procedure, or as soon as you are aware you need medical care. **In case of emergency, you or a family member should contact Horizon Member Services within 48 hours after the admission or procedure.**

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

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

The Medical 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) 224-1233.

If the proposed inpatient admission or treatment is medically necessary in accordance with such standards, it will be certified by the Medical Consultant. On the other hand, if other treatment is more appropriate, alternative treatment settings may be suggested. See page 37 for more information regarding precertification.

There's A Penalty If You Do Not Precertify

If you do not call to precertify a hospital admission or any of the procedures or tests listed, you will have to pay 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 Horizon Member Services as soon as you are aware your stay must be extended. The Medical Consultant can then work with your doctor to extend the certification of your hospital stay.

Your Share of Medical Expenses

American Water Medical Plans have been carefully designed to provide quality care and the most value for each dollar spent by you and the Company. Here is how 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. Copayments do not count toward meeting the annual deductibles.

- **Single Deductible Limit (per calendar year)**
  - $1,000 (Standard PPO, in-network)
  - $1,500 (Standard PPO, out-of-network)
  - $200 (Premium PPO, out-of network only; no deductible for in-network)

  This Calendar Year Deductible applies to all expenses incurred for Out-of-Network and for care for dependents who live permanently outside the Network.

- **Family Deductible Limit (per calendar year) must be met by expenses of more than one family member**
  - $3,000 (Standard PPO, in-network)
  - $4,500 (Standard PPO, out-of-network)
  - $600 (Premium PPO, out-of network only; no deductible for in-network)

This Calendar Year Deductible applies to all expenses incurred for Out-of-Network and for care for dependents who live permanently outside the Network.

In Network and Out of Network deductibles are separate deductibles.

Inpatient Hospital Copay

Under the Premium PPO, there is a separate $250 copayment for each confinement in an out-of-network hospital. This is a separate amount you pay for each hospital confinement. The Inpatient Hospital Copay 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 Copay 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 Copay.

- **Inpatient Hospital Copay**
  - $250 per confinement (Premium PPO, out-of network only)

  This Inpatient Hospital Copay applies to Inpatient Hospital Confinements, including Inpatient Alcoholism, Drug Abuse, and Mental Disorder confinements incurred for Out-of-Network and for care for dependents who live permanently outside the Network.

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

- **Emergency Room Copay**
  - $25 (Premium PPO, in- network and out-of network; waived if admitted)

  This separate Emergency Room Copay must be paid for each visit to a hospital's emergency room for emergency care. This copay will be waived if the person is admitted to the hospital as an inpatient immediately following the emergency room visit.

  The Emergency Room Copay also applies to Hospital Expenses incurred for emergency care provided by an Out-of-Network Provider and for care for dependents who live permanently outside the Network.

  Note: Standard PPO benefits are different than the PPO Benefits (see the chart which begins on page 8).

Coinsurance

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

If you use network doctors, hospitals or hospital alternatives, the plan generally pays as follows (although there may be other limits, such as limits on the number of treatments or visits):

	Plan Pays	You Pay	Up to Annual Out-of-Pocket Limit (single/family)
Standard PPO	80%	20%	$3,500 / $10,500
Premium PPO	90%	10%	$1,000 / $3,000

If you use out-of-network doctors, hospitals or hospital alternatives, the generally plan pays as follows (although there may be other limits, such as limits on the number of treatments or visits):

	Plan Pays	You Pay	Up to Annual Out-of-Pocket Limit (single/family)
Standard PPO	60%	40%	$4,000 / $12,000
Premium PPO	70%	30%	$3,000 per person

Your in-network coinsurance amounts do not count toward your out-of-network deductible and coinsurance limits.

Out-of-Pocket Limits

There is a limit to your share of medical expenses each calendar year, called the "out-of-pocket" limit. Your coinsurance amounts count toward these out-of-pocket limits, but copayments, deductibles and amounts you are required to pay to out-of-network providers in excess of the reasonable and customary charge ***do not*** count.

- **Out-of-Pocket Limits (single/family)**
  - $3,500 / $10,500 (Standard PPO, in-network)
  - $4,000 / $12,000 (Standard PPO, out-of-network)
  - $1,000 / $3,000 (Premium PPO, in-network)
  - $3,000 per person (Premium PPO, out-of-network)

If you reach your out-of-pocket limit during a calendar year, your covered expenses will be paid at 100% for the remainder of that year (in-network) and at 100% of reasonable and customary charges (out-of-network). If you do not reach your out-of-pocket limit, you must start accumulating expenses again in January.

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

Lifetime Maximum Benefit

Both the Standard and Premium PPO Plans provide an unlimited Lifetime Maximum Benefit for you and each covered member of your family.

Your Contributions

You pay your share of the cost for your benefits each pay cycle through convenient *pre-tax* payroll deductions. *Pre-tax* means that your contributions are withheld before federal (and in most cases, state (other than New Jersey) and local) income and FICA (Social Security) taxes are withheld. This reduces your taxable income and the amount of tax you pay. As a result, you have more take-home pay. Because your pre-tax contributions are not subject to FICA taxes, your Social Security benefit at retirement may be slightly reduced if your earnings are under the Social Security Taxable Wage Base ($94,200 for 2006; $97,500 for 2007). However, the loss in future retirement benefits should be more than offset by the current tax savings under the Plan.

Benefits Payable

American Water pays the majority of your benefit costs.

After any applicable deductible or copay amount, the Plan pays benefits at the Payment Percentage which applies to the type of Covered Medical Expense, except for any different benefit levels described elsewhere in this Summary Plan Description. If an expense is covered as one type of Covered Medical Expense, it cannot be covered as any other type.

Benefit Maximums

All maximums included in this Plan are combined maximums between Network and Out-of-Network, where applicable, unless specifically stated otherwise.

The following limitations apply to some of the benefits under the PPO Plans:

- **Private Duty Nursing Care**

  70 shifts per calendar year
- **Home Health Care**

  120 visits per calendar year

  (a "visit" is considered to be four hours or less in duration)
- **Skilled Nursing/Convalescent Facility**

  120 days per calendar year
- **Hospice Care**

  Inpatient- 90-day lifetime maximum

  Outpatient- $5,000 lifetime maximum
- **Short-Term Rehabilitation**

  60 days per calendar year
- **Private Room Limit**

The institution's semi-private rate

Covered Expenses

Inpatient Hospital Care

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

The Plan covers charges made by a hospital for room (semi-private only), board, and other hospital services and supplies for a person who is confined as a full-time inpatient for the treatment of an injury or illness.

Outpatient Hospital Care

The Plan covers charges made by a hospital for services and supplies for a person who is not confined as a full-time inpatient.

Skilled Nursing/ Convalescent Facility

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

The Plan covers charges made by a skilled nursing/convalescent facility for the following services and supplies 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. Charges for daily room and board in a private room over the Private Room Limit are not covered.
- 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 skilled nursing/convalescent facility, excluding private or special nursing, or doctors' services
- Medical supplies

The Plan does not cover skilled nursing/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 is limited to 120 visits 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 RN, or by an LPN if an RN is not available;
- Part-time or intermittent home health aide services for patient care;
- Physical, occupational, and speech therapy;
- Expenses covered to the extent they would have been covered under this Plan if the person had been confined in a hospital or skilled nursing/convalescent facility:
  - medical supplies, drugs, and medicines prescribed by a doctor, and
  - lab services provided by or for a home health care agency.

The Plan covers a maximum of 120 home health care visits 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 doctor for a routine physical exam given to you, your spouse, or your dependent child may be included as Covered Expenses.

Covered Medical Expenses include charges made by your doctor for a routine physical exam given to you, your spouse, or your dependent child.

A routine physical exam is a medical exam given by a doctor 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 doctor'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 the parent or guardian.

For a child under age six, Covered Medical Expenses 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 a child age six and over, Covered Medical Expenses do not include charges for more than one exam in a period of 24 consecutive months.

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

Charges for routine physical exams do not include:

- Services and supplies furnished by an out-of-network Provider;

- Services covered to any extent under any other part of this Plan or any other group plan sponsored by American Water;
- Services to diagnose or treat a suspected or identified injury or illness;
- Exams given to a person confined in a hospital or other facility for medical care;
- Services not given by a doctor 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;
- Doctor's office visits in connection with immunization or testing for tuberculosis.

Routine Hearing Exams

The American Water Plan covers a routine hearing exam by a participating provider once every 24 month under the Standard PPO Plan.

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

- 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 under the Standard PPO Plan.

Covered Medical Expenses do not include charges for:

- Ear or hearing exams to diagnose or treat an illness or injury;
- Drugs or medicines;
- Hearing care services or supplies covered to any extent under any other part of this Plan or any other group plan sponsored by American Water;
- Hearing care 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;

- Hearing care services or supplies which do not meet professionally accepted standards;
- Services or supplies received while the person is not covered;
- Exams given while the person is confined in a hospital or other facility for medical care;
- Exam required by an employer as a condition of employment, or that an employer is required to provide under a labor agreement or required by law;
- Services or supplies furnished by an out-of-network Provider.

Routine Pap Smear

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

Routine Mammogram

Covered Medical Expenses include charges incurred by a female for routine mammograms as follows:

- One baseline mammogram for women at least age 35 but less than age 40,
- One mammogram each calendar year for women age 40 or over.

Benefits Related to Breast Reconstruction

The Plan provides benefits related to breast reconstruction in compliance with the Women's Health and Cancer Rights Act of 1998. This federal law states that group health plans that provide medical and surgical benefits for mastectomy must provide certain additional benefits related to breast reconstruction.

If you (or a covered dependent) are receiving mastectomy benefits, you are entitled to 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 and treatment for physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The Plan will determine the manner of coverage in consultation with you and your attending doctor. Coverage for breast reconstruction and related services will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

The charges made by a doctor 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. Charges for the reversal of a sterilization procedure are not covered.

Annual Gynecological Exam

You may visit your network gynecologist once a year for a routine exam.

Expenses incurred for one routine self-referred gynecological exam per calendar year, performed by a network doctor, will be considered a Covered Medical Expense. The routine gynecological exam, including one Pap smear and related laboratory expenses, is considered Office Care. No coverage is provided if the exam is performed by an out-of-network Provider.

Maternity

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 Horizon 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.

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.

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 dental expenses, but 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, "doctor" includes a dentist.

- Surgery needed to treat a fracture, dislocation, or wound or to cut out teeth partly or completely impacted in the jawbone. 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 covered only 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 of the mouth, jaws, jaw joints, and supporting tissues (including bones, muscles, and nerves). 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.

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 to 8 hours will be considered one private duty nursing shift.

Charges made by an RN or LPN or nursing agency for "skilled nursing services" are included as Covered Medical Expenses. No other charges made by an RN or LPN or a nursing agency are covered. As used here, "skilled nursing services" means these services:

- Visiting nursing care by an RN or LPN. Visiting nursing care means a visit of up to 4 hours for the purpose of performing specific skilled nursing tasks.
- Private duty nursing by an RN or LPN 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.

"Skilled nursing care" does not include:

- The part (or all) of any nursing care that does not require the education, training, and technical skills of an RN or LPN, such as transportation, meal preparation, charting of vital signs, and companionship activities.
- 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 or 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 doctor 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 RN or LPN.

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 full-time inpatient for pain control and other acute and chronic symptom management.

Charges for daily room and board in a semi-private room over the Private Room Limit are not included. 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 doctor Expenses

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

■ Hospice Care Facility

■ Hospital

■ Skilled Nursing/Convalescent Facility, or

■ Doctor

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 precertified), up to a lifetime maximum of $5,000.

■ Part-time or intermittent nursing care by an RN or LPN for up to eight hours per day.

■ Medical social services under the direction of a doctor, including:

- assessment of the person's social, emotional, and medical needs, and the home and family situation;

  - identification of available community resources;
  - assisting the person to obtain resources needed to meet the person's assessed needs.
- Psychological and dietary counseling.
- Consultation or case management services by a doctor.
- Physical and occupational therapy.
- Part-time or intermittent home health aide services (consisting mainly of caring for the person) for up to eight hours per day.
- Medical supplies, drugs, and medicines prescribed by a doctor.

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

- A doctor 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 consisting mainly of caring for the person) for up to eight hours per day;
  - medical supplies, drugs, and medicines prescribed by a doctor;
  - psychological and dietary counseling.

Charges for the following services are not included:

- Bereavement counseling.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling, including estate planning or the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to care of the person, including sitter or companion services for either the person who is ill or to other members of the family, transportation, housecleaning, and maintenance of the house.
- Respite care. This is care furnished during a period of time when the person's family or usual caretaker is unable or unwilling to attend to the person's needs.

Short-Term Rehabilitation

Charges made by a doctor, 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,

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.

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.

Charges for Short-Term Rehabilitation services are covered for a maximum of 60 days per calendar year, as long as the treatment is precertified.

Charges for the following services are not covered:

- Services covered to any extent under any other part of this Plan or any other group plan sponsored by American Water.
- Services received while the person is confined in a hospital or other facility for medical care.
- Services not performed by a doctor or not under his or her direct supervision.
- Services rendered by a physical, occupational, or speech therapist who lives 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.

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 Horizon.

Emergency Care

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

If emergency care is received in a hospital emergency room while a person is not a full-time inpatient, the hospital's charges will be Covered Medical Expenses and paid at the Payment Percentage.

"Emergency care" means the first treatment given in a hospital 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, the emergency described above could, as determined by Horizon, 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 in an Emergency Room

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

Other Covered Medical Expenses

Other Covered Medical Expenses include:

- Doctor's charges.
- 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 made to withstand prolonged use and used mainly in the treatment of an illness or injury. It must be suited for use in the home, not normally of use to persons without an illness or injury, and not used to alter 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 is covered only if Horizon agrees 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 is covered only if Horizon agrees 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 similar equipment.

- Artificial limbs and eyes. 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 of the injury or onset of illness to the first hospital where treatment is given.

Pre-Existing Conditions

Pre-Existing Conditions do not apply under any Horizon 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.

Inpatient hospital confinements must be precertified to qualify for the highest level of benefits paid by the Plan. Covered Medical Expenses incurred on any day not certified during the confinement will be paid as shown below if:

- A person becomes confined in a hospital as a full-time inpatient, and
- It has not been certified that the confinement (or any day of the confinement) is necessary, and
- The confinement has not been ordered and prescribed by your doctor.

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, you will have to pay a $150 penalty charge before benefits are paid for covered services.

Benefits for 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 the 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 precertification number on your ID card or Horizon Member Services at (800) 355-BLUE (2583) 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 doctor.

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, excluding services and supplies because they are not necessary will not be applied to expenses for hospital room and board.

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

An urgent admission is one required as 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 doctor 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 doctor, or the hospital must call Horizon Member Services to request certification within 48 hours of the start of the confinement. If the call cannot be made 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 doctor 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 doctor's opinion, it is necessary for you to be confined for a longer time than already certified, you, the doctor, or the hospital may

request that more days be certified by calling the precertification number on your ID card or Horizon Member Services at **(800) 355-BLUE (2583).** This must be done on or before 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 doctor.

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

Precertification is required for confinements in a skilled nursing/convalescent facility or hospice, 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 shown below if incurred:

- While a person is confined in a skilled nursing/convalescent facility or hospice; or
- For services or supplies 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 doctor.

Facility Expenses

If certification has been requested and denied, no benefits will be paid for Skilled Nursing/Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for room and board. Benefits for all other Skilled Nursing/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 the confinement) is not necessary, no benefits will be paid for Skilled Nursing/Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for room and board. For all other Skilled Nursing/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 the confinement) is necessary, skilled nursing/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 precertification number on your ID card or Horizon Member Services at (800) 355-BLUE (2583). 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 the confinement or service or supply are excluded by any other terms of this Plan, except that, to the extent a day of confinement has been certified, excluding services and supplies because they are not necessary will not apply to:

- Skilled Nursing/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, excluding services or supplies because they are not necessary will not apply to the service or supply.

If a person's doctor believes that the person needs more days of confinement or services or supplies beyond those which have been already certified, a call must be made to the precertification number on your ID card or Horizon Member Services at **(800) 355-BLUE (2583)** 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 have been certified and the person later requires hospital confinement for pain control or acute symptom management, any other certification requirement in this Plan will be waived for any such day of hospital confinement.

Certification for Certain Procedures and Treatments

Certification for certain procedures and treatments is required:

- Before the procedure is performed, or
- Before the treatment starts, unless the procedure or treatment has been ordered and prescribed by your doctor.

When any of the procedures or treatments shown below will be performed on an inpatient or outpatient basis, Covered Medical Expenses for 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 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.

Certain procedures or treatments require precertification before they are performed, regardless of whether done on an inpatient or outpatient basis. Call Horizon to determine if your procedure requires precertification.

You or the provider performing the procedure or treatment must call the precertification number on your ID card or Horizon Member Services at **(800) 355-BLUE (2583)** 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 of the procedure or the date treatment begins. 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 of the procedure or the date treatment begins.

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 described below 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 doctor.

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, expenses up to the Excluded Amount will not be considered Covered Medical Expenses.

Other Facility Expenses Incurred for the Services of a Doctor

If certification has been requested and denied, or if certification has not been requested and the confinement is necessary, only expenses after the $150 precertification penalty will 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, services and supplies applicable to hospital and treatment facility room and board will not be excluded as "unnecessary."

To request certification, you must call the precertification number on your ID card or Horizon Member Services at (800) 355-BLUE (2583). 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.

"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 Horizon, 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 doctor believes that the person needs more days of confinement beyond those which have already been certified, additional days of confinement must be certified on or before 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 in either a hospital or treatment facility, 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. Charges for daily room and board in a private room over the Private Room Limit are not covered.
- Other necessary services and supplies.

The above expenses are covered only 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 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 the Benefits Service Center; directly from Horizon's website (www.horizonblue.com/nationalaccounts); or by contacting Horizon Member Services at (800) 355-BLUE (2583).

How Your Benefits Are Paid

American Water has contracted with Horizon to assist in administering benefits under the PPO Plans as the Claims Administrator. Your claims will be paid as soon as Horizon receives the necessary written proof supporting your claim. In order to speed claims processing, Horizon 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, Horizon 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 doctor office visits, you should never pay a provider directly until you receive an Explanation of Benefits (EOB).

Filing Medical Claims

When you use a network provider, you will not have to complete a Medical Plan Benefits Request form. The network provider 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.
- Include your Identification number on all claims, including claims for your dependent(s), and be sure to sign the form.
- 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 the service was provided,
  - the name of the health care professional providing the 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 doctor/supplier section of the claim form if he or she has not given you an itemized statement.

If you have other group coverage (or Medicare coverage) that pays benefits before the American Water Plan, you will need to provide Horizon with a copy of the other carrier's Explanation of Benefits (EOB) reflecting the benefits paid under the other coverage for the expenses being submitted for payment to this Plan.

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

Horizon Blue Cross Blue Shield of New Jersey
P.O. Box 1219
Newark, NJ 07101-1219

If you have any questions about the status of your claim, call Horizon Member Services at **(800) 355-BLUE (2583)**.

The Exclusive Provider Organization (EPO) Plan

The Exclusive Provider Organization (EPO) Plan

The Plans are self-insured by American Water. Horizon provides certain administrative services under the Plan.

Like the PPOs, the Exclusive Provider Organization (EPO) Plan is self-insured by American Water, with certain administrative services provided by Horizon. However, it offers **no** out-of-network benefits.

If you want to receive benefits under the EPO Plan, you must receive care from a doctor, hospital, or health care provider within the Horizon network. As you may know, Horizon maintains a nationally recognized health care provider network. In fact, most providers and hospitals currently used by our employees are members of the Horizon network. If you cover any college-age dependents or any of your dependents live permanently outside the network area, you should consider carefully before enrolling in the EPO option.

To locate participating network providers, call (800) 810-BLUE (2583) or use the Provider Finder at:

www.horizonblue.com/national accounts.

With the EPO Plan, you do not need to select a Primary Care Physician before you receive medical care, nor do you need to obtain referrals to see a specialist. However, when you need care, you must use a provider within the Horizon network in order to receive benefits.

EPO Plan Advantages

Because you are using a provider within the Horizon network:

- Your healthcare providers file all your claims;
- Your doctor initiates all required precertification;
- 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 Horizon has negotiated with them. (See the Glossary for a definition of "reasonable and customary charge").

Coverage for Dependents Who Live Outside the Network Area

Because the EPO Plan offers **no** out-of-network benefits, expenses incurred by your dependents who live outside the network area will **not** be covered. Therefore, if your child is away at school or lives permanently outside the network area (with another parent or stepparent, for example), you should consider carefully before enrolling in the EPO option.

Coverage When You Are Traveling

If you are traveling (and out of a Horizon network area) and you need medical care in a non-emergency situation, the EPO Plan offers **no** out-of-network 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 doctor. A 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 burns, and suspected heart attack.

You will be paid at the Plan's benefit level for emergency care – 24 hours a day, 365 days a year – whether you are at home or away, in- or out-of-network. When you need emergency care, it is important to seek **immediate** care at the nearest appropriate facility.

When a covered person is confined as a full-time inpatient as the result of an **emergency** admission, you, the person's doctor, or the hospital must call Horizon Member Services to request certification within 48 hours of the start of the confinement. If the call cannot be made 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.

Precertification

Precertification is an important feature of the EPO Plan. In order for you to receive the highest level of benefits available, Horizon must be notified to precertify any hospital admission 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.

You, the network hospital, or your network doctor will initiate all required precertification.

Procedures Which Must Be Precertified

- All hospital and skilled nursing/convalescent facility admissions
- Home health care, hospice care, and skilled nursing care
- Inpatient treatment for substance abuse and mental disorders

Call Horizon for all other procedures.

How to Request Precertification for a Medical Procedure or Admission

Certain procedures or treatments require precertification before they are performed, regardless of whether done on an inpatient or outpatient basis. Call Horizon to determine if your procedure requires precertification.

You or the provider performing the procedure or treatment must call the precertification number on your ID card or Horizon Member Services at **(800) 355-BLUE (2583)** to request certification.

The hospital or doctor should call at least 14 days before any scheduled admission or outpatient procedure, or as soon as the need for medical care is evident. **In case of emergency, you or a family member should contact Horizon Member Services within 48 hours after the admission or procedure.**

At Member Services, a Medical Consultant will ask:

- The patient's name and Identification number,
- The type of surgical procedure or test ,
- The doctor's name and telephone number, and
- When the procedure is scheduled.

The Medical 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) 224-1233.

If the proposed inpatient admission or treatment is medically necessary in accordance with such standards, it will be certified by the Medical Consultant. On the other hand, if other treatment is more appropriate, alternative treatment settings may be suggested. See page 63 for more information regarding precertification.

There's A Penalty For Not Precertifying

If a hospital admission or any of the procedures or tests listed is not precertified, you will have to pay a $150 penalty charge before benefits are paid for covered services.

If Your Hospital Stay Is Longer Than Expected

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

Your Share of Medical Expenses

American Water Medical Plans have been carefully designed to provide quality care and the most value for each dollar spent by you and the Company. Here is how we share the costs of these valuable benefits.

Deductibles

The EPO Plan has no deductibles.

Copayments

You pay your share of expenses through copays.

When you visit your network provider, you pay a flat fee for certain network services. This fee is called a "copayment" or "copay." If you are admitted to a network hospital or hospital alternative, you will generally be covered at 100% after a $100 copay per admission.

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

No Out-of-Pocket Limit

The EPO Plan has no "out-of-pocket" limit. You are responsible for paying all of your copayments for the entire calendar year.

Lifetime Maximum

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

Your Contributions

American Water pays the majority of your benefit costs.

You pay your share of the cost for your benefits each pay cycle through convenient *pre-tax* payroll deductions. *Pre-tax* means that your contributions are withheld before federal (and in most cases, state (other than New Jersey) and local) income and FICA (Social Security) taxes are withheld. This reduces your taxable income and the amount of tax you pay. As a result, you have more take-home pay. Because your pre-tax contributions are not subject to FICA taxes, your Social Security benefit at retirement may be slightly reduced if your earnings are under the Social Security Taxable Wage Base ($94,200 for 2006; $97,500 for 2007). However, the loss in future retirement benefits should be more than offset by the current tax savings under the Plan.

Benefits Payable

After any applicable copay amount, the EPO Plan generally pays 100% of Covered Medical Expenses, except for any different benefit levels described elsewhere in this Summary Plan Description. If an expense is covered as one type of Covered Medical Expense, it cannot be covered as any other type.

Benefit Maximums

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

- **Skilled nursing facility**

  100 days per calendar year
- **Short-Term Rehabilitation (for acute conditions only)**

  60 days per calendar year if certified by your doctor
- **Private Room Limit**

  The institution's semi-private rate

Covered Expenses

Inpatient Hospital Care

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

The Plan covers charges made by a Horizon network hospital for room, board, and other hospital services and supplies for a person who is confined as a full-time inpatient for the treatment of an injury or illness.

Outpatient Hospital Care

The Plan covers charges made by a Horizon network hospital for services and supplies for a person who is not confined as a full-time inpatient.

Skilled Nursing/ Convalescent Facility Care

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

The Plan covers charges made by a Horizon network skilled nursing/convalescent facility for the following services and supplies 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. Charges for daily room and board in a private room over the Private Room Limit are not covered.
- 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 skilled nursing/convalescent facility, excluding private or special nursing, or doctors' services
- Medical supplies

The Plan does not cover skilled nursing/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 expenses from a Horizon network provider are covered if:

- The charge is made by a home health care agency,
- 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 RN, or by an LPN if an RN is not available;
- Part-time or intermittent home health aide services for patient care;
- Physical, occupational, and speech therapy;
- Expenses covered to the extent they would have been covered under this Plan if the person had been confined in a hospital or skilled nursing/convalescent facility:
  - medical supplies, drugs, and medicines prescribed by a doctor, and
  - lab services provided by or for a home health care agency.

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 doctor for a routine physical exam given to you, your spouse, or your dependent child may be included as Covered Expenses.

Covered Medical Expenses include charges made by a Horizon network doctor for a routine physical exam given to you, your spouse, or your dependent child.

A routine physical exam is a medical exam given by a network doctor 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 doctor'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 the parent or guardian.

Charges for routine physical exams do not include:

- Services and supplies furnished by a non-network provider;
- Services covered to any extent under any other part of this Plan or any other group plan sponsored by American Water;
- Services to diagnose or treat a suspected or identified injury or illness;
- Exams given to a person confined in a hospital or other facility for medical care;
- Services not given by a doctor 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;
- Doctor's office visits in connection with immunization or testing for tuberculosis.

Routine Hearing Exams

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

- 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 do not include charges for:

- Ear or hearing exams to diagnose or treat an illness or injury;
- Drugs or medicines;
- Hearing care services or supplies covered to any extent under any other part of this Plan or any other group plan sponsored by American Water;

- Hearing care 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;
- Hearing care services or supplies which do not meet professionally accepted standards;
- Services or supplies received while the person is not covered;
- Exams given while the person is confined in a hospital or other facility for medical care;
- Exam required by an employer as a condition of employment, or that an employer is required to provide under a labor agreement or required by law;
- Services or supplies furnished by a non-network provider.

Routine Pap Smear

Covered Medical Expenses include charges for one routine Pap smear and related laboratory expenses each calendar year. Services must be furnished by EPO network providers.

Routine Mammogram

Covered Medical Expenses include charges incurred by a female for routine mammograms as follows:

- One baseline mammogram for women at least age 35 but less than age 40,
- One mammogram each calendar year for women age 40 or over.

Services must be furnished by EPO network providers.

Benefits Related to Breast Reconstruction

The Plan provides benefits related to breast reconstruction in compliance with the Women's Health and Cancer Rights Act of 1998. This federal law states that group health plans that provide medical and surgical benefits for mastectomy must provide certain additional benefits related to breast reconstruction.

If you (or a covered dependent) are receiving mastectomy benefits, you are entitled to 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 and treatment for physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The Plan will determine the manner of coverage in consultation with you and your attending doctor. Coverage for breast reconstruction and related services will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

The charges made by a Horizon network doctor 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. Charges for the reversal of a sterilization procedure are not covered.

Annual Gynecological Exam

Expenses incurred for one routine gynecological exam per calendar year, performed by a Horizon network doctor, will be considered a Covered Medical Expense. The routine gynecological exam, including one Pap smear and related laboratory expenses, is considered Office Care. No coverage is provided if the exam is performed by an out-of-network provider.

Maternity

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 and services furnished by network providers. If expenses are incurred after the coverage ceases, they will be considered for benefits only if satisfactory evidence is furnished to Horizon 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.

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.

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 dental expenses when services are furnished by network providers, but 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 by a network provider 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, “doctor” includes a dentist.

- Surgery needed to treat a fracture, dislocation, or wound or to cut out teeth partly or completely impacted in the jawbone. 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 covered only 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 of the mouth, jaws, jaw joints, and supporting tissues (including bones, muscles, and nerves). 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.

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 Services

Charges made by a Horizon network RN or LPN or nursing agency for "skilled nursing services" are included as Covered Medical Expenses. No other charges made by an RN or LPN or a nursing agency are covered. As used here, "skilled nursing services" means these services:

Coverage for private duty nursing is payable at 100% with no limit on days.

- Visiting nursing care by an RN or LPN. Visiting nursing care means a visit for the purpose of performing specific skilled nursing tasks.
- Private duty nursing by an RN or LPN if the person's condition requires skilled nursing care and visiting nursing care is not adequate.

"Skilled nursing care" does not include:

- The part (or all) of any nursing care that does not require the education, training, and technical skills of an RN or LPN, such as transportation, meal preparation, charting of vital signs, and companionship activities.
- 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 or 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 doctor 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 RN or LPN.

Hospice Care

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

Inpatient hospice care must be precertified to be covered at the highest level payable under the EPO.

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

Inpatient Care

Room and board and other services and supplies furnished to a full-time inpatient for pain control and other acute and chronic symptom management. Charges for daily room and board for a semi-private room over the Private Room Limit are not included.

Facility and Doctor Expenses

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

- Hospice Care Facility
- Hospital
- Skilled Nursing/Convalescent Facility, or
- Doctor

Outpatient Care

The Plan covers charges made by a Hospice Care Agency for the following outpatient services and supplies (if precertified and furnished by EPO network providers).

- Part-time or intermittent nursing care by an RN or LPN.
- Medical social services under the direction of a doctor, including:
  - assessment of the person’s social, emotional, and medical needs, and the home and family situation;
  - identification of available community resources;

  - assisting the person to obtain resources needed to meet the person's assessed needs.
- Psychological and dietary counseling.
- Consultation or case management services by a doctor.
- Physical and occupational therapy.
- Part-time or intermittent home health aide services (consisting mainly of caring for the person).
- Medical supplies, drugs, and medicines prescribed by a doctor.

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

- A doctor 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 consisting mainly of caring for the person),
  - medical supplies, drugs, and medicines prescribed by a doctor,
  - psychological and dietary counseling.

Charges for the following services are not included:

- Bereavement counseling.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling, including estate planning or the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to care of the person, including sitter or companion services for either the person who is ill or to other members of the family, transportation, housecleaning, and maintenance of the house.
- Respite care. This is care furnished during a period of time when the person's family or usual caretaker is unable or unwilling to attend to the person's needs.

Short-Term Rehabilitation

Charges made by a network doctor, or an in-network 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.

Charges for Short-Term Rehabilitation services are covered for a maximum of 60 days per calendar year, as long as the treatment is certified by the patient's doctor.

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 Horizon.

Charges for the following services are not covered:

- Services covered to any extent under any other part of this Plan or any other group plan sponsored by American Water.
- Services received while the person is confined in a hospital or other facility for medical care.
- Services not performed by a doctor or not under his or her direct supervision.
- Services rendered by a physical, occupational, or speech therapist who lives 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 a hospital emergency room.

If emergency care is received in a hospital emergency room (in- or out-of-network) while a person is not a full-time inpatient, the hospital's charges will be Covered Medical Expenses and paid at the Payment Percentage after a $35 copayment (waived if admitted).

"Emergency care" means the first treatment given in a hospital 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, the emergency described above could, as determined by Horizon, 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 in an Emergency Room

If non-emergency care treatment is received in a hospital emergency room (whether in- or out-of-network) while a person is not a full-time inpatient, no benefits will be paid.

Other Covered Medical Expenses

Other Covered Medical Expenses include the following, when furnished by network providers:

- Doctor's charges.
- 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 made to withstand prolonged use and used mainly in the treatment of an illness or injury. It must be suited for use in the home, not normally of use to persons without an illness or injury, and not used to alter 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 is covered only if Horizon agrees 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 is covered only if Horizon agrees 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 similar equipment.

- Artificial limbs and eyes. 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 of the injury or onset of illness to the first hospital where treatment is given.

Pre-Existing Conditions

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

Certification for Hospital Admissions

Inpatient hospital confinements must be precertified.

Inpatient hospital confinements must be precertified to qualify for the highest level of benefits paid by the Plan.

No benefits will be paid by the Plan for inpatient hospital charges at non-network hospitals.

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 100% after a $100 copay per admission.

If certification has not been obtained, you will have to pay a $150 penalty charge before benefits are paid for covered services.

Other Covered Medical Expenses

Call the precertification number on your ID card or Horizon Member Services at (800) 355-BLUE (2583) 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 doctor.

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, excluding services and supplies because they are not necessary will not be applied to expenses for hospital room and board.

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

An urgent admission is one required as 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 doctor 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 doctor, or the hospital must call Horizon Member Services to request certification within 48 hours of the start of the confinement. If the call cannot be made 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 doctor 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 doctor's opinion, it is necessary for you to be confined for a longer time than already certified, you, the doctor, or the hospital may request that more days be certified by calling the precertification number on your ID card or Horizon Member Services at **(800) 355-BLUE (2583).** This must be done on or before 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 doctor.

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

Precertification is required for confinements in a skilled nursing/convalescent facility or hospice, 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 shown below if incurred:

- While a person is confined in a skilled nursing/convalescent facility or hospice; or
- For services or supplies 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 doctor.

Facility Expenses

If certification has been requested and denied, no benefits will be paid for Skilled Nursing/Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for room and board. Benefits for all other Skilled Nursing/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 the confinement) is not necessary, no benefits will be paid for Skilled Nursing/Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for room and board. Benefits for all other Skilled Nursing/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 the confinement) is necessary, skilled nursing/convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement 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.

To get certification you must call the precertification number on your ID card or Horizon Member Services at (800) 355-BLUE (2583). 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 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 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 the confinement or service or supply are excluded by any other terms of this Plan, except that, to the extent a day of confinement has been certified, excluding services and supplies because they are not necessary will not apply to:

- Skilled nursing/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, excluding services or supplies because they are not necessary will not apply to the service or supply.

If a person's doctor believes that the person needs more days of confinement or services or supplies beyond those which have been already certified, a call must be made to the precertification number on your ID card or Horizon Member Services at **(800) 355-BLUE (2583)** 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 have been certified and the person later requires hospital confinement for pain control or acute symptom management, any other certification requirement in this Plan will be waived for any such day of hospital confinement.

Certification for Certain Procedures and Treatments

Certification for certain procedures and treatments is required:

- Before the procedure is performed, or
- Before the treatment starts, unless the procedure or treatment has been ordered and prescribed by your doctor.

When any of the procedures or treatments shown below will be performed on an inpatient or outpatient basis, Covered Medical Expenses for 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 100%.
- If certification has not been requested and the procedure or treatment is necessary, expenses in excess of the copayment (if applicable) will be considered Covered Medical Expenses and will be payable at 100%.

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

Certain procedures or treatments require precertification before they are performed, regardless of whether done on an inpatient or outpatient basis. Call Horizon to determine if your procedure requires precertification.

You or the provider performing the procedure or treatment must call the precertification number on your ID card or Horizon Member Services at **(800) 355-BLUE (2583)** 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 of the procedure or the date treatment begins. 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 of the procedure or the date treatment begins.

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 furnished by a Horizon network provider for the effective treatment of alcoholism, drug abuse, or mental or nervous disorders will be paid at 100% as described below if incurred:

- While a person is confined in a network hospital or treatment facility,
- It has been certified that such confinement is necessary, and
- The confinement has been ordered and prescribed by your doctor.

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, you will have to pay a $150 penalty charge before benefits are paid for covered services.

Other Facility Expenses Incurred for the Services of a Doctor

If certification has been requested and denied, or if certification has not been requested and the confinement is necessary, only expenses after the $150 precertification penalty will 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, services and supplies applicable to hospital and treatment facility room and board will not be excluded as “unnecessary.”

To request certification, you must call the precertification number on your ID card or Horizon Member Services at (800) 355-BLUE (2583). 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.

"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 Horizon, 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 doctor believes that the person needs more days of confinement beyond those which have already been certified, additional days of confinement must be certified on or before 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 in a Horizon network hospital or treatment facility, 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. Charges for daily room and board in a private room over the Private Room Limit are not covered.
- Other necessary services and supplies.

The above expenses are covered only if they are incurred during the first 30 days of all such confinements during any one calendar year.

For alcoholism and drug abuse, benefits will be paid for only 90 days during your lifetime.

Benefits will be paid at 100%.

Outpatient Treatment

Expenses incurred in a Horizon network hospital or facility 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, will be considered Covered Medical Expenses.

Benefits will be paid at 100% after a $25 copayment, up to a maximum of 20 visits per calendar year for mental/nervous conditions.

For alcohol/drug treatment, benefits will be paid at 100% for the first treatment and at the lesser of a $25 copayment or 50% of the covered charges for the second and subsequent courses of treatment.
There is a 60-visit maximum per calendar year and a 120-visit lifetime maximum.

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 the Benefits Service Center; directly from Horizon's website (www.horizonblue.com/nationalaccounts); or by contacting Horizon Member Services at (800) 355-BLUE (2583).

How Your Benefits Are Paid

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

With the exception of the copayment for doctor's office visits, you should never pay a provider directly until you receive an Explanation of Benefits (EOB).

Filing Medical Claims

Because the EPO Plan provides in-network benefits only and all claims are paid directly to the provider, you will not have to file any Medical Plan Benefits Request forms.

If you have other group coverage (or Medicare coverage) that pays benefits before the American Water Plan, you will need to provide Horizon with a copy of the other carrier's Explanation of Benefits (EOB) reflecting the benefits paid under the other coverage for the expenses being submitted for payment to this plan.

Provisions That Apply To All Horizon Medical Plans

Provisions That Apply to All Horizon Plans

This section describes General Exclusions that apply under all Horizon Plans.

Coverage is not provided for the following charges:

- Those for services and supplies not necessary, as determined by Horizon, 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 doctor or dentist.
- Those for care, treatment, services, or supplies that are not prescribed, recommended, and approved by the person's attending doctor or dentist.
- Those for, or in connection with, services or supplies that are, as determined by Horizon, considered to be 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 Horizon 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 Horizon will take into account the results of a review by a panel of independent medical professionals. They will be selected by Horizon. This

panel will include professionals who treat the type of illness involved.

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

- 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 doctor or intern rendered in that capacity.
- Those to the extent they are not reasonable charges, as determined by Horizon.
- 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 Horizon 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.
- 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 doctor, 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 Network 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.

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 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 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 you 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).

If the American Water Plan is determined to be the primary plan (the plan that pays its benefits first), it will pay its regular benefits in full without regard to any payment that may be made under any other plan.

If the American Water Plan is determined to be the secondary plan (the plan that pays its benefits after the primary plan pays benefits), it will pay a reduced amount of benefits that will in no event cause the total benefit from all plans to exceed the benefit that would have been paid

by the American Water Plan if it had been the primary plan. However, if benefits under the primary plan are reduced because a covered person does not comply with the plan provisions (such as penalties resulting from the failure to comply with cost management provisions of the plan), the amount of the reduction will not be considered for payment under the American Water Plan.

For example, if you have Standard PPO coverage the primary plan pays 70% of eligible charges to an in-network provider, the American Water Plan will pay an additional 10% of covered charges for a total benefit equal to 80% of covered charges which is the benefit the American Water Plan would have paid as the primary plan.

When other coverage exists in addition to your American Water 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 of benefit 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.

Horizon has 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 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 Medical Plan are payable after the automobile insurance policy benefits have been paid, even if you have designated the American Water Medical Plan as primary to your automobile insurance coverage in exchange for reduced automobile insurance premiums.

Third Party Liability and Subrogation

General Principle

When you or your dependent receive benefits under the Plan which are related to medical expenses that are also payable under Workers' Compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, you or your dependent shall reimburse the Plan for the related benefits received out of any funds or monies you or your dependent recovers from any third party.

Specific Requirements and Plan Rights

Because the Plan is entitled to reimbursement, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that you or your dependent may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to

reimbursement is regardless of the manner in which the recovery is structured or worded, and even if you or your dependent has not been paid or fully reimbursed for all of their damages or expenses.

The Plan's share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

The Plan may enforce its subrogation or reimbursement rights by requiring you or your dependent to assert a claim to any of the benefits to which you or your dependent may be entitled. The Plan will not pay attorneys fees or costs associated with the claim or lawsuit without express written authorization from the Employer.

If the Plan should become aware that you or your dependent has received a third party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to you or any of your dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of you or your dependents.

Participant Duties and Actions

By participating in the Plan you and your dependents consent and agree that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, you and your dependents agree to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Once you or your dependent has any reason to believe that you or they may be entitled to recovery from any third party, you or your dependent must notify the Plan. And, at that time, the you and your dependent (and your or their attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle you or your dependent to any payment, amount or recovery from a third party.

If you or your dependent fails or refuses to execute the required subrogation/reimbursement agreement, the Plan may deny payment of any benefits to you and any of your dependents until the agreement is

signed. Alternatively, if you or your dependent fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of you or your dependent, your or your dependent's acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement.

You and your dependent consent and agree that you or they shall not assign your or their rights to settlement or recovery against a third person or party to any other party, including their attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Employer.

Recoupment

The Plan has the right to recover any mistaken payment, any overpayment, any payment that is made to any individual who was not eligible for that payment or any payment that was required to have been made to the Plan under the "Third Party Liability and Subrogation" section above. The Plan, or its designee, may withhold or offset future benefit payments, sue to recover such amounts, or may use any other lawful remedy to recoup any such amounts.

No Assignment of Benefits

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void. The payment of benefits directly to a health care provider, if any, shall be done as a convenience to the covered person and shall not constitute an assignment of benefits under the Plan.

When an Active Employee Is Eligible for Medicare

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

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.

Any rule for coordinating "other plan" benefits with those under this Plan will be applied.

When Coverage Is Terminated

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 may continue your coverage when you are not actively at work. If you are not at work due to illness or injury, American Water medical coverage will be continued for the length of your approved leave of absence, not to exceed 24 months from the date you are disabled as long as appropriate contributions are made.

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.

You may be entitled to continue your medical coverage (see “Continuation of Health Coverage” on page 189).

Certificate of Creditable Coverage

When you or your covered dependents terminate coverage under the Plan, a Notice of Creditable Coverage will be issued to you specifying your coverage dates under the health plan and any probationary periods you were required to satisfy. The certificate 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 may require that you submit a copy of this form when you apply for coverage.

The Notice of Creditable Coverage will be issued to you when you terminate coverage with the group and, if applicable, at the expiration of any continuation period. The Plan 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.

Qualified Medical Child Support Orders (QMCSOs)

A “Qualified Medical 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 covered under 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 must treat an alternate recipient as an eligible dependent and must deduct any applicable contributions from the employee’s pay. A QMCSO may also require the claim administrator to issue claim payments directly to the health care provider, the alternate recipient, or his or her legal representative. A custodial parent or guardian may be designated to receive claim payments on the child's behalf. American Water is required to furnish an alternate recipient or his or her legal representative a copy of the Summary Plan Description. In addition, the alternate recipient or his or her legal

representative may receive, without charge, a copy of the Plan's QMCSO procedures.

If American Water receives a QMCSO affecting one of your children, you and your child will be notified. Once American Water has determined that the medical child support order is qualified, you and your child will be advised. American Water will enroll the child and instruct Horizon 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 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.

Coverage for the child will become effective on the date of such court order.

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. 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 before the date of any adjustment.

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

If your medical coverage ceases under a PPO or the EPO Plan, you may be able to convert your group coverage to a personal medical policy.

If your medical coverage ends under a PPO or the EPO Plan, you may be able to convert your group coverage to a personal medical policy underwritten by Horizon. 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 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.

In addition, 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 are eligible and you elect to participate in the American Water Retiree Medical Plan, this conversion privilege will not again be available to you.

You must apply for a personal policy within 31 days after coverage ends or would otherwise end without a provision to continue coverage for retired employees. The 31 days start on the date coverage actually ends, even if the person is still eligible for benefits because of a total disability.

Horizon 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 Horizon 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. In addition, 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 Horizon according to American Water 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 Horizon 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 Horizon 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 should contact Horizon at (800) 355-BLUE (2583) to obtain the telephone number of your local Blue Cross-Blue Shield office. When you reach the local office, ask to speak with a representative in the Consumer Individual Sales Department and request that a package on converting your coverage be mailed to you.

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 Horizon’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 the American Water Plan.

Disease Management Program

Horizon's Disease Management 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 doctor(s) to remain personally involved in their care. Employees with one of the conditions listed below may be identified as eligible for program participation.

- 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 doctor or other health care provider, Horizon; or his or her Employer; and
- who is approved by Horizon as a participant.

For additional information or to take part in this program, call Horizon at **(800) 355-BLUE (2583)**.

The Prescription Drug Benefit Program

Prescription Drug Benefit Program

Horizon's Prescription Drug Benefit program is administered by Caremark. You are automatically covered by the Prescription Drug Benefit if you enroll in an American Water Medical Plan.

Note: Prescription Drug Benefits for Hawaii employees are covered under the HMSA plan.

The program offers you two ways to receive medications – at a retail pharmacy or by mail-order.

- For your short-term and immediate prescription drug needs, you may use local participating pharmacies that have agreed to charge discounted prices.
- For medications you use on an extended or maintenance basis, you may purchase up to a 90-day supply through Caremark, the administrator of the mail-order program. They will be delivered by mail directly to your home.

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

What You Pay for Prescription Drugs

Your coinsurance and copays are the same under both PPO options and the EPO option.

Retail Pharmacy – Up to a 34-Day Supply		
	Standard or Premium PPO	**EPO**
Generic	You pay 10%	You pay 10%
Preferred Brand	You pay 20%	You pay 20%
Non- Preferred Brand	You pay 20%	You pay 20%

Mail-Order Program – Up to a 90-Day Supply		
	Standard or Premium PPO	**EPO**
Generic	You pay $14	You pay $14
Preferred Brand	You pay $30	You pay $30
Non- Preferred Brand	You pay $70	You pay $70

Note: Coinsurance and copayments 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.

Preferred Drug List

Your Prescription Drug coverage levels are based on the plan's Preferred Drug List – also called a "formulary." When your prescription medication is on the Preferred Drug List, you pay a lower cost than when the drug is not on the Preferred Drug List. If you receive a prescription for a drug that is not on the list, you should ask your doctor if there is another drug on the Preferred Drug List for your specific condition.

As part of our commitment to provide the best Prescription Drug program possible, we continue to seek ways to help control the rising costs of health care without compromising quality. As a result, the Horizon's Prescription Drug Guide is continually reviewed to help ensure that the list of preferred medications remains responsive to the needs of the member and the prescriber.

In general, medications are moved to non-preferred status for one or more of the following reasons:

- A generic equivalent product becomes available,
- New safety or clinical effectiveness information supports the move to non-preferred status, or
- Drug use information shows that preferred alternatives with better patient compliance rates are available.

To find out if your prescription is on the Preferred Drug List, call Horizon Member Services at (800) 355-BLUE (2583) or log on to www.horizonblue.com/nationalaccounts. Click on "Pharmacy Services" in the lower right and then on "Preferred Drug Guide."

Save With Generics

When using your Prescription Drug plan, you will pay less if you receive a prescription for a generic drug. The Food and Drug

Administration (FDA) regulates generic drugs and requires that they contain the same active ingredients, strength, and dosage as the original brand-name drug. Although generic and brand-name drugs work the same way in the body and have the same risks and benefits, generic drugs cost significantly less than their brand-name counterparts.

When you receive a prescription from your doctor, ask him or her to prescribe a generic or to allow for generic substitution.

Covered Drugs

The Prescription Drug Program covers drugs that require a doctor's written prescription and are medically necessary for the treatment of illness or injury. Covered drugs include, but are not limited to:

- Federal legend drugs,
- State restricted drugs,
- Compounded medications,
- Injectable drugs, including insulin, needles, and syringes, and
- Oral contraceptives

Specialty Drugs

Specialty Drugs (also called Specialty Pharmaceuticals) are a class of medications typically produced through biotechnology (sometimes known as biologicals), administered by injection, and/or requiring special patient monitoring and handling.

Horizon members who are required to take a specialty pharmaceutical must obtain their medication from a specialty pharmacy contracted by Horizon. These pharmacies will provide members with a high level of prescription delivery service along with the following:

- Drug/disease-specific education and support;
- Convenient home or doctor office delivery;
- Claims assistance;
- Easy ordering with a dedicated toll-free number;

- Helpful follow-up care calls to remind members when it is time to refill a prescription, check on therapy progress, and answer questions.

If you have any questions, experience any difficulty in filling your specialty pharmaceutical prescription, or would like to obtain a listing of specialty pharmacies or pharmaceuticals, please call Caremark Member Services at (866) 881-5603. In most cases your doctor will advise you if your medication is a specialty drug.

How to Use the Prescription Drug Program

If you use a participating pharmacy, you will receive discounted prices and will not need to complete a claim form. Otherwise, you will pay more and must complete a claim form to receive reimbursement. You can locate participating pharmacies by calling Horizon Member Services at (800) 355- BLUE (2583) or by logging on to www.horizonblue.com/nationalaccounts. Click on “Pharmacy Services” in the lower right and then on “Choosing a Pharmacy” to access the Pharmacy Locator.

Using a Participating Pharmacy

When you need medication immediately, simply present your ID card at a participating pharmacy and pay a percent of the discounted prescription cost for a 34-day supply of medication. You will pay 20% for brand names and 10% for generic drugs. There is no deductible to meet. You will have no claim forms to complete and no waiting for reimbursement.

Using an Out-of-Network Pharmacy

When you have a prescription filled at *non-participating* pharmacy, you must pay the regular charge. To receive reimbursement, submit a claim form to Horizon 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. If your claim is approved, your reimbursement check should arrive 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 a long-term or maintenance basis. The program allows you to receive up to a 90-day supply of medication as follows: $14 for generic, $30 for preferred brand, and $70 for non-preferred brand.

Mail-Order Service Option

The mail order service option gives you the convenience of ordering medication for direct delivery by mail to your home, office, or other location. Your doctor may call in your new prescription to Caremark, or you can simply fill out the mail service order form and send it in with your prescription(s).

Ordering for the First Time

For your first mail service prescription, complete the Participant Profile/Order Form in your Welcome Package. You can also print an order form from www.caremark.com. Log in with your login ID and password, click on the "Prescriptions and Coverage" tab, and select "Print Forms" from the menu on the left.

Attach your 90-day supply prescription and mail it along with the appropriate co-payment to:

Caremark
P.O. Box 830070
Birmingham, AL 35283-0070

Your prescription should arrive within 10 to 14 days from the date Caremark receives your order.

Ordering Refills

You can order refills online, by mail, or over the phone.

To place a refill order online:

- Go to www.caremark.com and log in with your login ID and password. Click on the "Prescriptions and Coverage" tab, select Refill Prescriptions, and choose the prescription(s) that you want to refill. Because the system retains your information, you do not need to complete an order form for each refill.

To place a refill order by mail:

- Use the computerized pre-printed Participant Profile/Order Form and pre-addressed envelope that comes with each Caremark prescription mailed to you. If your address, doctor, or health condition information changes, please note them on the form and be sure to make the same changes to your account on www.caremark.com.

To place a refill order over the phone:

Call Caremark toll-free at **(800) 213-0879** using a touch-tone phone. This service is available 24 hours a day, seven days a week. Enter the patient's Identification number and year of birth. For payment of your share, enter your credit card number and expiration date.

Drugs and Supplies 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 doctor'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
  - Injectable drugs (other than insulin) and specialty drugs
  - 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
- 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.

Prescription Drug Plan Administrator

Caremark Rx, Inc. (www.caremark.com) administers the program, with a national retail pharmacy network of over 60,000 participating pharmacies and seven mail service pharmacies. Their online tools and other communications provide you with convenient service, personal care and attention, and up-to-date information.

No Assignment of Benefits

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void. The payment of benefits directly to a health care provider, if any, shall be done as a convenience to the covered person and shall not constitute an assignment of benefits under the Plan.

The Dental Plans

Dental Benefits

To help you take good care of your teeth, American Water 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 any of American Water Medical Plans are also enrolled in a Dental Plan. This valuable benefit is self-insured by American Water, and Aetna provides certain administrative services under this Plan. The provisions of the Plan will remain effective only while you are covered under the group contract.

There are two dental plans – Standard and Premium. The dental plan you receive depends on the medical plan you select, since dental benefits are bundled with the medical plan. The Standard PPO medical plan includes Standard PPO Dental, and the Premium PPO and EPO medical plans include Premium PPO Dental. If you opt out of medical and select dental/vision coverage you will be enrolled in the Dental Premium PPO Plan. *Note: If you are a Hawaii employee enrolled in the HMSA medical plan, you will be enrolled in the Premium PPO Dental Plan.*

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

The dental plans offer both in-network and out-of-network benefits, but your benefit levels are higher (and your out-of-pocket costs lower) when you use Aetna in-network dentists. To find a dentist or see if your dentist participates in Aetna's provider network, visit www.aetna.com or contact Member Services at (800) 292-4366.

If you choose an out of network dentist you will be responsible for any provider charges in excess of what the Plan pays in addition to any deductible and coinsurance amount. Plan benefits will be based on reasonable and customary charges.

Dental Plan Summary Chart

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

	Standard PPO Dental	Premium PPO Dental
Deductible (single / family)	$100 / $200	$50 / $100
Preventive Care	80% of covered expenses after deductible	100% of covered expenses with no deductible
Basic and Major Services	50% of covered expenses after deductible	80% of covered expenses after deductible
Calendar Year Maximum	$1,000	$1,000
Orthodontia	Not covered	50% of covered expenses after deductible $1,500 lifetime maximum (covers employees and eligible dependents)

Covered Dental Expenses

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

Note: You are responsible for any amounts billed by providers that are in excess of the amount paid by the Plan.

The Premium PPO Dental Plan pays the following benefits for Covered Dental Expenses up to the payment percentage:

- 100% of Preventive (Type A) expenses with no deductible.
- 80% of Restorative and Major Services (Type B) expenses after the deductible.
- 50% of Orthodontia (Type C) expenses after the deductible, up to a lifetime maximum of $1,500.

The Standard PPO Dental Plan pays the following benefits for Covered Dental Expenses up to the payment percentage:

- 80% of Preventive (Type A) expenses after the deductible.
- 50% of Restorative and Major Services (Type B) expenses after the deductible.
- There is no coverage for Orthodontia (Type C) expenses.

Both Dental plans pay the dentist's charges for the services and supplies listed below which, for the condition being treated, are in Aetna's sole determination:

- 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.
- Other X-rays (up to 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 (Premium PPO Dental Plan Only)

A dentist's charges for services and supplies for Orthodontic Treatment are included as Covered Dental Expenses under the Premium PPO Dental Plan. In addition to all other terms of this dental benefit:

- The Plan pays 50% of Covered Dental Expenses after the deductible, up to a $1,500 lifetime maximum, for employees and eligible dependents.
- Benefits will not exceed the Orthodontic Maximum for all expenses incurred by a family member in his or her lifetime, even if there is a break in coverage.
- Please note: All claims for dental benefits must be submitted within 24 months from the start of treatment.

Advance Claim Review

You should request an Advance Claim Review of any dental program 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 the dentist's charges are expected to be $150 or more, details of the proposed course of treatment and charges to be made should be filed with Aetna. Please contact Aetna Member Services at (800) 292-4366 for additional details and to obtain forms. Aetna will then estimate the benefits and notify you and your dentist before treatment starts. Advance review is not required as a condition of receiving benefits, but it will let you know what to expect as far as Plan benefits if you obtain more expensive treatment.

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 less than you expect if an Advance Claim Review is not made or if any required verifying material is not furnished. Benefits will be reduced by the amount of 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, as determined by Aetna:

- 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 104 for more information.

Prosthesis Replacement Rule

Certain replacements or additions to existing dentures or bridgework will be covered under this Plan. Aetna must receive satisfactory proof 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, and 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 and takes place within 12 months from the date the immediate temporary denture was first installed.

Explanation of Some Important Plan Provisions

Calendar Year Deductible

The Calendar Year Deductible is the amount of Covered Dental Expenses you must pay each calendar year before the Plan pays benefits.

Family Deductible Limit

The Family Deductible Limit is the amount of Covered Dental Expenses your family must pay before the Plan pays benefits. When these expenses exceed the Family Deductible Limit, the Plan pays benefits at the percentage listed on the Dental Chart on page 98. The family deductible limit must be met by more than one person.

Coinsurance

Coinsurance is the amount you must pay out of your own pocket for Covered Dental Expenses after you meet the calendar year deductible.

Calendar Year Maximum Benefit

The Calendar Year Maximum Benefit is the most the Plan will pay for all dental expenses incurred by a covered person in a calendar year. It applies even if there is a break in coverage.

Coordination of Benefits

In many families, both husbands and wives work and may be eligible for benefits under more than one group medical or dental plan. In such situations, the various plans "coordinate" benefits to determine how covered expense will be paid by the American Water 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 the American Water Plans.

If the American Water Plan is determined to be the primary plan (the plan that pays its benefits first), it will pay its regular benefits in full without regard to any payment that may be made under any other plan.

If the American Water Plan is determined to be the secondary plan (the plan that pays its benefits after the primary plan pays benefits), it will pay a reduced amount of benefits that will in no event cause the total benefit from all plans to exceed the benefit that would have been paid by the American Water Plan if it had been the primary plan. However, if benefits under the primary plan are reduced because a covered person does not comply with the plan provisions (such as penalties resulting from the failure to comply with cost management provisions

of the plan), the amount of the reduction will not be considered for payment under the American Water Plan.

For example, if you have Standard PPO Dental coverage and receive Preventive Care Services, the primary plan pays 70% of eligible charges to an in-network provider, the American Water Plan will pay an additional 10% of covered charges for a total benefit equal to 80% of covered charges which is the benefit the American Water Plan would have paid as the primary plan.

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 Plan will be limited.

Limitations

When the Alternate Treatment part of this Plan applies, benefits will be limited. Here are some examples:

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 and 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 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.

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 may continue your coverage when you are not actively at work. If you are not at work due to illness or injury, American Water dental coverage will be continued for the length of your approved leave of absence, not to exceed 24 months from the date you are disabled as long as appropriate contributions are made.

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.

You may be entitled to continue your dental coverage (see "Continuation of Health Coverage" on page 189).

Benefits After Termination of Coverage

If your dental coverage ends while you are not totally 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 dental coverage ends because medical coverage ends 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

For 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 expenses:

- Services and supplies not necessary, as determined by Aetna, for the diagnosis, care, or treatment of disease or injury. This applies even if they are prescribed, recommended, or approved by the person's attending dentist.
- Care, treatment, services, or supplies that are not prescribed, recommended, and approved by the person's attending dentist.
- Treatment by someone other than a licensed dentist. (The Plan will cover some treatments by a licensed dental hygienist if supervised by a dentist, including scaling of teeth, cleaning of teeth, and topical application of fluoride.)
- Services or supplies determined by Aetna to be 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 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.

- Services of a resident doctor, dentist, or intern rendered in that capacity.
- Charges which Aetna determines not to be reasonable.
- Charges for services and supplies which are covered in whole or in part under any other part of this Plan, or under any other group benefits plan provided by American Water.
- Charges that are made only because there is health coverage.
- Charges that a covered person is not legally obliged to pay.
- Charges 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.
- Charges 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, including but not limited to charges for personalization or characterization of dentures, except to the extent needed to repair an injury which occurs while the person is covered under this Plan.
- Charges for routine dental exams or other preventive services and supplies.
- Charges for acupuncture therapy, unless performed by a doctor as a form of anesthesia in connection with surgery covered under the Plan.
- Charges for sealants.

- Charges for the replacement of a prosthetic device that is lost, missing, or stolen.
- Charges for services or supplies for orthodontic treatment, except as specifically provided.
- Charges for services or supplies to increase vertical dimension, such as dentures, crowns, inlays and onlays, bridgework, or any other appliance or service.

Any exclusion above will not apply to the extent that:

- Coverage is specifically provided by name in this Summary Plan Description, 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 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. (See page 101 for information on filing Orthodontic Claims) Claims must be in writing and must include proof of the nature and extent of the expense. To obtain Dental Benefits Request forms, call Aetna Member Services at **(800) 292-4366** or visit their website at www.aetna.com.

How Your Benefits Are Paid

The Dental Plan is administered by Aetna. Claims will be paid as soon as Aetna receives the necessary written proof supporting your claim.

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.

Fast processing of your claim depends on complete, accurate information. When filing a claim under the Dental Plan, please remember to:

- Complete all items under applicable sections of the claim form. Unanswered questions will cause delay in processing your claim.
- Be sure to include your Identification number on all claims, including claims for your dependent(s), and be sure to sign the form.
- 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 before this Plan, you must provide Aetna with a copy of the other carrier's Explanation of Benefits (EOB) reflecting the benefits paid under the other coverage when you submit expenses for payment under this Plan.

Send the completed claim form and itemized bill(s) to:

Aetna
P.O. Box 14094
Lexington, KY 40512-4094

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

No Assignment of Benefits

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void. The payment of benefits directly to a health care provider, if any, shall be done as a convenience to the covered person and shall not constitute an assignment of benefits under the Plan.

Your Contributions

You pay your share of the cost for your benefits each pay cycle through convenient *pre-tax* payroll deductions. *Pre-tax* means that your contributions are withheld before federal (and in most cases, state (other than New Jersey) and local) income and FICA (Social Security) taxes are withheld. This reduces your taxable income and the amount of tax you pay. As a result, you have more take-home pay. Because your pre-tax contributions are not subject to FICA taxes, your Social Security benefit at retirement may be slightly reduced if your earnings are under the Social Security Taxable Wage Base ($94,200 for 2006; $97,500 for 2007). However, the loss in future retirement benefits should be more than offset by the current tax savings under the Plan.

The Vision Plan

Vision Benefits

Healthy eyes and good vision are important to your overall well-being and quality of life. All employees and their dependents who enroll in any of American Water Medical Plans are also enrolled in the Vision Plan, since both vision and dental benefits are bundled with the medical plan. Employees may enroll in dental/vision coverage if they opt out of medical.

The Vision Plan is administered by EyeMed. EyeMed provides certain administrative and claim payment services under the Plan, but does not guarantee benefit payments. You can receive routine eye exams, corrective lenses, frames, and contacts through EyeMed's nationwide network of over 16,000 participating providers – optometrists, ophthalmologists, and optical retail locations.

The Vision Plan offers both in-network and out-of-network benefits, but your benefit levels are higher (and your out-of-pocket costs lower) when you use in-network providers.

To find a provider or to make sure your provider participates in the EyeMed network:

- Before you enroll: visit www.enrollwitheyemed.com/access.
- Once you are enrolled: visit www.eyemedvisioncare.com.

There are no ID cards with the EyeMed plan. Just call an EyeMed provider to make an appointment and furnish your Identification number.

Vision Benefits Summary Chart

The following chart provides a summary of your vision benefits. Keep in mind that the Network Providers column shows what *you* pay and the Out-of-Network Provider column shows what *the Plan* pays.

Vision Care Service	Member Cost at a Network Provider	Reimbursement at an Out-of-Network Provider
Vision Exam	$15 copay	U&C less $15 copay
Frames	$50 copay, $200 allowance; 80% of balance over $200	Up to $120
Standard Plastic Lenses • Single Vision • Bifocal • Trifocal • Lenticular	 $35 copay $50 copay $50 copay $50 copay	 Up to $25 Up to $40 Up to $55 Up to $70
Lens Options (paid by member and added to base price of the lens) • Tint (Solid and Gradient) • UV Coating • Standard Scratch-Resistance • Standard Polycarbonate • Standard Anti-Reflective • Standard Progressive (add-on to bifocal) • Other Add-Ons and Services	 $15 copay $15 copay $15 copay $40 copay $45 copay $65 copay 20% off retail price	N/A No Reimbursement
Contact Lenses (in lieu of Standard Plastic lenses) (includes fit, follow-up and materials) • Conventional • Disposables • Medically necessary	 $100 allowance; 15% off balance over $100 $100 allowance; 15% off balance over $100 Paid in full	 Up to $80 Up to $80 Up to $200
LASIK and PRK Vision Correction	15% off retail price OR 5% off promotional pricing (whichever results in the lower cost to the member)	N/A No Reimbursement
Frequency	Exams- once every 24 months Frames- once every 24 months Standard Plastic Lenses or Contact Lenses- once every 24 months	
Additional Purchases and Out-of-Pocket Discount: Member will receive a 20% discount on remaining balance at Participating Providers beyond plan coverage, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed's Providers' professional services or disposable contact lenses.		

Visiting an Out-of-Network Provider

All vision care services received from an out-of-network provider are paid up to a scheduled amount. You are responsible for paying any amount the provider charges in excess of that amount.

Services Not Covered

The Vision Plan does not cover:

- Orthoptics or vision training;
- Subnormal vision aids and associated supplemental testing;
- Aniseikonic lenses;
- Medical and/or surgical treatment of the eyes;
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the plan;
- Services provided as a result of Workers' Compensation Law;
- Non-prescription lenses (plano lenses) and non-prescription sunglasses (except for the 20% EyeMed discount);
- Two pair of glasses in lieu of bifocals;
- Services or materials provided by any other group benefit providing for vision;
- Benefit allowances provide no remaining balance for future use within same benefit period;
- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit period.

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 may continue your coverage when you are not actively at work. If you are not at work due to illness or injury, American Water vision coverage will be continued for the length of your approved leave of absence, not to exceed 24 months from the date you are disabled as long as appropriate contributions are made.

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.

You may be entitled to continue your vision coverage (see "Continuation of Health Coverage" on page 189).

Filing a Claim

When you visit an EyeMed network provider, you must present the provider with your Identification number. Your provider will submit the benefit form for you.

If you visit an out-of-network provider, you must pay the provider at the time you receive vision care services. You must then submit an EyeMed claim form and an itemized paid receipt to receive reimbursement. Your itemized receipt must include:

- Patient's name
- Date service began
- The services and materials received
- Amount paid

Claim forms and receipts should be mailed to:

EyeMed Vision Care
Attention OON Claims
P.O. Box 8504
Mason, OH 45040-7111

You can fax the form and receipts to: (866) 293-7373. You can also e-mail the form and receipts to: ooonclaims@eyemedvisioncare.com. Claim forms are available on EyeMed's website at www.eyemedvisioncare.com. You can also obtain forms by contacting EyeMed Member Services at (866) 939-3633.

EyeMed will not process claims submitted more than 12 months after the date of service or purchase.

No Assignment of Benefits

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void. The payment of benefits directly to a health care provider, if any, shall be done as a convenience to the covered person and shall not constitute an assignment of benefits under the Plan.

Your Contributions

You pay your share of the cost for your benefits each pay cycle through convenient *pre-tax* payroll deductions. *Pre-tax* means that your contributions are withheld before federal (and in most cases, state (other than New Jersey) and local) income and FICA (Social Security) taxes are withheld. This reduces your taxable income and the amount of tax you pay. As a result, you have more take-home pay. Because your pre-tax contributions are not subject to FICA taxes, your Social Security benefit at retirement may be slightly reduced if your earnings are under the Social Security Taxable Wage Base ($94,200 for 2006; $97,500 for 2007). However, the loss in future retirement benefits should be more than offset by the current tax savings under the Plan.

Flexible Spending Accounts

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 pre-tax dollars.

To help you meet the high costs of health and dependent care in the most cost-efficient manner, American Water offers two programs which allow you to pay for qualifying expenses using *pre-tax* dollars. You pay fewer taxes because those amounts are not subject to federal income or Social Security taxes. You keep more of what you earn, increasing your spendable income.

You make voluntary contributions on a pre-tax basis to spending accounts, from which you receive tax-free reimbursement to cover the cost of your qualifying medical and dependent care expenses.

Horizon administers the Flexible Spending Accounts on behalf of American Water.

The Health Care Spending Account reimburses you for most health-related expenses for yourself or your eligible dependents that are not reimbursable through any health benefit plans.

The Dependent Care Spending Account reimburses you for most dependent day care expenses for your qualifying dependents.

Reimbursements that you receive from your Health Care and/or Dependent Care Spending Accounts are tax-free to you.

Your contributions to your Health Care and/or Dependent Care Spending Accounts are deducted each pay cycle through convenient *pre-tax* payroll deductions. *Pre-tax* means that your contributions are withheld before federal (and in most cases, state and local) income and FICA (Social Security) taxes are withheld. (Note: If you are a resident of Pennsylvania, your contributions to the Dependent Care Spending Account will be subject to state income taxes. If you are a resident of New Jersey, your contributions to both the Health Care Spending Account and the Dependent Care Flexible Spending Account will be subject to New Jersey state income taxes.) Pre-tax contributions reduce your taxable income and the amount of tax you pay. As a result, you have more take-home pay. Because your pre-tax contributions are not subject to FICA taxes, your Social Security benefit at retirement may be slightly reduced if your earnings are under the Social Security Taxable Wage Base ($94,200 for 2006; $97,500 for 2007). However, the loss in future retirement benefits should be more than offset by the current tax savings under the Plan.

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 pre-tax 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 from the spending account for these expenses.

Here is an example of the potential tax savings with a Health Care Spending Account:

	With Account	Without Account
Annual Family Income	$50,000	$50,000
Pre-Tax Contributions to Account	$ 2,400	None
Taxable Income	$47,600	$50,000
Federal, State, and Social Security Taxes	$12,685	$13,325
After-Tax Health Care Expenses	None	$ 2,400
Net Spendable Income	$34,915	$34,275
Tax Savings (Extra Take-Home Pay)	**$ 640**	

Example uses tax rates of 15% federal, 4% state, and 7.65% Social Security

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 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.

If you are a regular full-time eligible employee (see "Eligibility" above), you are eligible to participate in the Health Care Spending Accounts as of the first day of the month following completion of one full month of continuous employment. You may enroll by completing and signing the appropriate 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 not permitted to make changes to your election amount during the Plan Year, except under certain circumstances (see page 123).

Eligible Dependents

Health Care expenses incurred by your eligible dependents can be reimbursed if the expenses are not covered by any medical, dental, vision, 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. For you to include these expenses, the person must have been your dependent either at the time the medical services were provided or at the time you paid the expenses.

In general, an eligible dependent is your spouse or any person whom you could claim as a dependent on your federal income tax return (without regard to that individual's gross income). As of January 1, 2006, the definition of “dependent child” for this purpose changed. A person generally qualifies as your dependent if he or she is a “qualifying child” or a “qualifying relative.”

A **qualifying child** is your son, daughter, stepchild, foster child, brother, sister, stepbrother, stepsister, or a descendant of any of them who is:

- Under age 19, under age 23 and a full-time student, or permanently and totally disabled;
- Lived with you for more than half of the year; and
- Did not provide over half of his or her own support for year.

A legally adopted child (or a child lawfully placed with you for legal adoption) is treated as your own child. Special rules apply to expenses paid before and after the adoption or placement. A child of divorced

or separated parents can be treated as a dependent of both parents. Again, special rules apply.

A **qualifying relative** is your:

- Son, daughter, stepchild, foster child, or a descendant of any of them (for example, your grandchild);
- Brother, sister, or a child of either of them;
- Father, mother, or an ancestor or sibling of either of them (for example, your grandmother, grandfather, aunt, or uncle);
- Stepbrother, stepsister, stepfather, stepmother, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law; or
- Any other person (other than your spouse) who lived with you all year as a member of your household if your relationship does not violate local law.

You should consult your own tax advisor to determine whether your child or other relative is eligible to be your dependent.

How the Account Works

The spending account does not replace your medical benefits. It is a separate plan that reimburses you for qualifying expenses that are not covered, or only partially covered, by your Medical, Dental, or Vision Plan or by any other source (such as a spouse's plan).

When you have an eligible medical expense, you pay the bill. You can be reimbursed for these expenses from your account by filing a claim form. (See page 128.)

For additional convenience, you will be issued a debit card. Use the card to pay for eligible medical expenses just as you would use your bank debit card. The money is automatically debited from your Health Care Spending Account. You should keep copies of all receipts for any expenses you pay for from your Health Care Spending Account in case further substantiation is required.

Claim Documentation

Your debit card will permit all transactions to be made in the pharmacy at the point of sale. This includes prescription and over-the-counter items. Internal Revenue Service (IRS) regulations require documentation to verify that claims are legitimate. Therefore, any transaction that does not match a copayment from the American Water Medical Plan or Prescription Drug Plan or is not otherwise clearly a medical expense based on the information obtained from the vendor's inventory system at the point of sale, will be audited by Horizon.

If you are audited for a transaction, you (the member) are required to provide documentation to validate the expense. Return the letter to

Horizon along with a receipt or Explanation of Benefits (EOB) which includes the following:

- Provider
- Service(s) received or item(s) purchased
- Date of service
- Amount of expenses incurred

Horizon's Customer Service area will review the transaction. If it is eligible under IRS regulations and the supporting documentation is approved, no further action will be required. If any portion of the transaction is deemed ineligible according to IRS regulations, you (the member) will be responsible for returning those funds.

How Much Can I Contribute?

During open enrollment (or your 31-day enrollment period), you should estimate what you will spend during the next Plan Year (or the balance of the current Plan Year) (January 1 to December 31, plus the 2½ month grace period, see below) on unreimbursed medical expenses. We will deduct from your paycheck the amount of money you choose to set aside, in equal amounts over the course of the calendar year.

You may elect to contribute up to $3,000 per year to your Health Care Spending Account.

You may elect to contribute up to $3,000 per year to the Health Care Spending Account. There is a minimum contribution of $120 per calendar year. If your spouse also has 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.

The amount available to you for reimbursement for qualifying expenses incurred during the Plan Year (plus the 2½ month grace period) 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. *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 April 30 of the following year for health care expenses incurred during the Plan Year and the grace period (the following January 1 – March 15).

According to IRS rules, any amounts remaining in your spending account after the deadline for submitting claims incurred during the Plan Year (plus the 2½ month grace period) will be 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 employee or to another plan or account (such as the Dependent Care Spending Account). Therefore, you should plan carefully before you make your annual contribution election. Any

forfeited amounts are used by American Water to reduce future administrative expenses.

The claims accumulation period for the Health Care Spending Account is 14½ months – the current 12-month Plan Year (January 1 – December 31) plus the period January 1 through March 15 of the following calendar year. The deadline to submit claims for reimbursement from your Health Care FSA is April 30 of the following year. You must be an active participant or COBRA participant as of December 31 in order to take advantage of the grace period. Expenses incurred during the grace period that are not applied against Health Care Spending Account balance for the prior Plan Year can be applied against the Health Care Spending Account for the current Plan Year. For example, if you establish a Health Care Spending Account for 2007, eligible expenses incurred during the period January 1, 2008 – March 15, 2008, can be applied against your 2007 account balance. If you have exhausted your 2007 account balance or you do not submit the grace period expenses by April 30, 2008, you can apply those expenses against your 2008 Health Care Spending Account, if any. If you do not have a 2008 Health Care Spending Account, you would not be able to be reimbursed for those grace period expenses.

Can I Change the Amount of My Contributions?

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 correspond with, a change in status affecting eligibility. The following events are changes in status:

- **Change in employee's legal marital status** (marriage, death of spouse, divorce, legal separation, or annulment).
- **Change in the number of employee's dependents** (gain a child through birth, adoption, placement for adoption, or newly-eligible dependent; loss of dependent through death).
- **Change in dependent's eligibility status** (dependent qualifies or no longer qualifies because of age, student status, or marriage).

Expenses Eligible for Reimbursement

Only "qualifying" expenses can be reimbursed through the Health Care Spending Account. These include:

- 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.

- Deductibles or copayments you have paid under any type of health care plan.
- Over-the-counter medicines and drugs purchased without a prescription, provided they are for the diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body. The over-the-counter drug must be more than just beneficial to general health and not "cosmetic" in nature.

  Some over-the-counter drugs have a dual purpose, serving a personal/cosmetic or general health purpose as well as a medical purpose. These drugs will require a letter from a doctor stating the medical condition or disease that is being treated.

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 Horizon FSA at (800) 224-4426.

Keep in mind that the expenses you submit for reimbursement may not be covered or reimbursed by other insurance or another source, including a plan sponsored by your spouse's employer, Medicare, Workers' Compensation, automobile insurance, or any recovery or settlement from a lawsuit.

Below is a list of some of the health care expenses eligible for reimbursement from your spending account. Only healthcare expenses not reimbursed by insurance can be claimed.

For additional information, call Horizon FSA at (800) 224-4426. You can also refer to IRS Publication 502 ("Medical and Dental Expenses"). You can request a copy of Publication 502 from your local IRS office or go online at www.irs.gov/publications/p502. But keep in mind, not all expenses listed in Publication 502 are eligible (like insurance premiums) and some expenses not listed in the publication are eligible (such as some over-the-counter drugs and medicines).

- Acupuncture (excluding remedies)
- Adoption
- Adult diapers
- Alcoholism treatment
- Ambulance
- Artificial insemination
- Artificial limbs/teeth
- Birth control
- Braille books/magazines
- Chiropractic treatment
- Christian Science practitioners
- Coinsurance/deductibles
- 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
- Crutches
- Deductibles
- Dental treatment and oral surgery (non-cosmetic only)
- Dentures
- Diagnostic fees
- Dietary supplements and vitamins with doctor's letter of medical necessity
- Doctor fees (cosmetic procedures not eligible)
- Drug addiction treatments
- Drug and medical supplies (i.e. syringes, needles, etc.)
- Excess of reasonable and customary charges scheduled, annual, or lifetime maximums
- Eye care/exams
- Eye surgery (cataracts, LASIK, etc.)
- Eyeglasses (prescription only)
- Guide dogs
- Hearing aids/exams
- Hearing devices and batteries
- Home health care
- Hospital bills
- Insulin
- In-vitro fertilization
- Laboratory fees
- Nursing home costs
- Orthodontia (non-cosmetic only)
- Orthopedic devices
- Over-the-counter drugs that are medically necessary like allergy medications, aspirin, or antacids (see list below)
- Oxygen
- Prescribed medicines
- Psychiatric treatment
- Psychologist's fees
- Routine physicals and other non-diagnostic services or treatments
- Smoking-cessation over-the-counter drugs

- Smoking cessation programs
- Specialized car equipment for disabled persons
- Speech therapy
- Sterilization
- Surgical fees
- Transplants (except hair)
- Vaccinations and immunizations
- Vitamins, with doctor's letter of medical necessity
- Weight loss programs
- Weight-loss over-the-counter drugs with doctor's letter of medical necessity
- Well-baby care
- Wheelchairs
- X-ray fees

Over-The-Counter Items

The following over-the-counter items qualify for reimbursement under the Health Care FSA Plan:

- Antiseptics
- Asthma medications
- Cold, flu, and allergy medications
- Diabetic supplies
- Ear/eye care
- Health aids
- Pain relief
- Personal test kits
- Skin care
- Stomach care

Dual Use Items

The following dual use items qualify for reimbursement under the Health Care Spending Account with a letter of medical necessity from the patient's doctor:

- Adhesive or elastic bandages
- Blood pressure meter
- Cold or hot compresses
- Eye drops
- Foot spa
- Gauze and tape
- Gloves and masks
- Herbs
- Leg or arm braces

- Massagers
- Minerals
- Multivitamins
- Saline nose drops
- Special supplements
- Special teeth cleaning system
- Thermometers

Expenses Not Eligible for Reimbursement

The following are not considered qualifying healthcare expenses and cannot be reimbursed from the Health Care Spending Account:

- Bleaching/bonding of teeth
- Contact lens insurance
- 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
- Dancing lessons
- Diaper services for children
- Electrolysis
- Expenses for general health purposes, such as fitness, exercise, or health club dues unless recommended by a doctor for a particular medical condition
- Expenses for weight loss programs *unless* recommended by a doctor to treat obesity
- Expenses in excess of the amount you have elected to contribute to the Health Care Spending Account
- Expenses of someone who is not an eligible dependent
- Funeral expenses
- Hair restoration (procedures, drugs, or medications)
- Hair transplants
- Health club or gym memberships for general health
- Household help
- Insurance premiums (including COBRA premiums)
- Liposuction
- Marriage and family counseling
- Maternity clothes
- Over-the-counter items, drugs, or medications that are not medically necessary or are not prescribed by your doctor
- Premiums you or your spouse pay for insurance coverage
- Rogaine, when used for cosmetic purposes; that is, to stimulate growth, and not for a specific medical condition

- School tuition
- Swimming lessons
- Transportation costs of a disabled person to and from work
- Vacation or travel costs to improve health
- 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.*

Over-the-Counter Expenses Not Eligible for Reimbursement

The following over-the-counter items do not qualify for reimbursement from the Health Care FSA:

- Aromatherapy
- Baby bottles and cups
- Baby oil
- Baby wipes
- Breast enhancement system
- Cosmetics
- Cotton swabs
- Dental floss
- Deodorants
- Facial care
- Feminine care
- Fragrances
- Hair regrowth
- Low "carb" foods
- Low calorie foods
- Oral care
- Petroleum jelly
- Shampoo and conditioner
- Skin care
- Spa salts
- Sun tanning products
- Toothbrushes

Submitting Claims

You may be reimbursed from your Health Care Spending Account by completing a *Claim for Reimbursement* form, which can be downloaded from www.horizon-healthcare.com/fsa.

Any itemized bills that you submit should contain, at a minimum, the following information:

- 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.

Sign and date the claim form. Attach copies of bills, invoices, or other written statements from a third party that support each reimbursement request and mail or fax to:

Healthcare
3 Penn Plaza East PP-05S
Newark, NJ 07105-2200
Fax: (973) 466-6499 or (973) 274-2215

You will receive an Explanation of Payment (EOP) statement from Horizon 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 (FMLA Leave) from American Water, your pre-tax payroll deductions to the Health Care Spending Account will stop. You may continue to make contributions on an after-tax basis only by sending a monthly check to American Water.

Termination of Employment

If you terminate or retire from American Water, your pre-tax payroll deductions to the Health Care Spending Account will stop. Under certain circumstances, you may continue participating under COBRA and make contributions on an after-tax basis by sending a monthly check to American Water.

You may still continue to submit claims for reimbursement of expenses incurred **before** your date of termination.

The Dependent Care Spending Account

The cost of caring for your dependents while you work can be more affordable when you participate in the American Water Dependent Care Spending Account.

The Dependent Care Spending Account allows you to contribute money on a pre-tax basis to an account set up for you. These amounts can be used to reimburse you for most daycare or eldercare expenses you might incur for your qualifying dependents.

Here is an example of the potential tax savings with a Dependent Care Spending Account:

	With Account	Without Account
Annual Family Income	$50,000	$50,000
Pre-Tax Contributions to Account	$ 5,000	None
Taxable Income	$45,000	$50,000
Federal, State, and Social Security Taxes	$11,993	$13,325
After-Tax Dependent Care Expenses	None	$ 5,000
Net Spendable Income	$33,007	$31,675
Tax Savings (Extra Take-Home Pay)	**$ 1,332**	

Example uses tax rates of 15% federal, 4% state, and 7.65% Social Security

Eligibility

If you are a regular full-time eligible employee (see "Eligibility" above), you are eligible to participate in the Dependent Care Spending Accounts as of the first day of the month following completion of one full month of continuous employment. You may enroll by completing and signing the appropriate 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 can enroll by completing and signing the Flexible Spending Account section on your Enrollment Form. You will have the opportunity to change your elections in the fall of every year, effective for the upcoming plan year. You are not permitted to make changes to your election amount during the Plan Year, except under certain circumstances (see page 135).

Qualifying Dependents

Expenses are reimbursable for care of the following qualifying dependents:

- your child, grandchild, brother or sister who is under age 13, who resides in your household for more than one-half of the year and who does not provide more than one-half of his or her own support for the year;
- a disabled spouse who resides in your household for more than one-half of the year; and
- a disabled relative or household member who is principally dependent on you for support and who resides in your household for more than one-half of the year.

In the case of a child who receives over one-half of his or her support during the calendar year from his or her parents (i) who are divorced or legally separated under a decree of divorce or separate maintenance, (ii) who are separated under a written separation agreement, (iii) who live apart at all times during the last six months of the year, (iv) who have agreed that the custodial parent will not claim the child as an income tax exemption, and (v) where such child is in the custody of one or both parents for more than one-half of the year, such child will be considered the dependent of both parents, regardless of the child's place of residence of the amount of support provided by either parent. Contact your tax advisor or refer to IRS Publication 503 (Child and Dependent Care Expenses) for more information.

How the Account Works

When you have eligible dependent care expenses, you pay the bill and submit a reimbursement claim to Horizon, along with a copy of the bill. You can be reimbursed for these expenses from your account by filing a claim form, **assuming that you have enough money in your account.** If not, you will be reimbursed up to the amount in your account and the remainder of the claim will be held until the balance in your Dependent Care Spending Account is sufficient to cover the bill.

Keep in mind, however, that because you are contributing to the spending account through payroll deductions, you will have a period of increased expenses. You will have to pay your dependent care provider, as well as have payroll deductions, before receiving reimbursement from your account.

How Much Can I Contribute?

You may contribute up to a maximum of $5,000 per year, regardless of the actual number of qualifying dependents you have. Normally, amounts reimbursed from your Dependent Care Spending Account are tax-free to you. However, federal law states that the amount excluded from your gross income cannot exceed, in any calendar year (under all

dependent care plans in which you or your spouse may participate) the lesser of:

- $5,000 ($2,500 if you are married and filing separate federal income tax returns);
- Your annual income; or
- Your spouse's annual income.

If your spouse is (1) a full-time student for at least five months during the year or (2) physically and/or mentally disabled, there is a special rule to determine his or her annual income. To calculate the income, determine your spouse's actual taxable income (if any) earned each month that he or she is a full-time student or disabled. Then, for each month, compare this amount to either $250 (if you claim expenses for one dependent) or $500 (if you claim expenses for two or more dependents). The amount you use to determine your spouse's annual income is the greater of the actual earned income or 12 times the assumed monthly income amounts of either $250 or $500.

If you are married and filing separate federal income tax returns, the $2,500 limit described above will not apply if you are (1) legally separated or (2) separated for more than six (6) months and pay for more than half of the household expenses.

By making an election under the Plan, you are representing to the Company that your contributions to the Plan are not expected to exceed these limits.

To qualify for tax-free treatment, you are required to list on your federal income tax return the names and taxpayer identification numbers of any person who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. The identification number of a care provider who is an individual and not a care center is that individual's Social Security number. You should make your care provider aware of this reporting requirement.

You may elect to contribute up to $5,000 per year (or your or your spouse's earned wages, whichever is less) to your Dependent Care Spending Account.

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 a full-time student, the IRS considers him or her to be gainfully employed, with earned income of $250 per month (if you have one qualifying dependent) or $500 per month (if you have two or more qualifying dependents) for each month the spouse is a student. To be considered a "full-time student" as defined by the IRS, your spouse must maintain full-time status at a college or university during at least five months of the year.

Determining How Much to Contribute

The amount you elect to contribute will depend upon the amount you anticipate you will need to cover your dependent care expenses for the Plan Year (January 1 – December 31). You should compare the tax benefit you would receive with the Dependent Care Spending Account to the benefit that you would receive with the Federal child and dependent care tax credit (see below), and then choose between them. For additional details about the Federal tax credit, see IRS Publication 503 ("Child and Dependent Care Expenses") and IRS Tax Topic 602 (www.irs.gov/taxtopics/tc602.html). You can request a copy of Publication 503 from your local IRS office or go online at www.irs.gov/publications/p503.

Federal Earned Income Credit. A tax credit available under current tax law is the earned income credit. This credit also reduces the federal tax you have to pay on a dollar-for-dollar basis, but is calculated somewhat differently from the child care credit described above. The credit is available to individuals with a child who is under age 19 (under age 24 if a student) or who is totally and permanently disabled. An additional credit is available to individuals with a child who is under one year old. The credit does not depend on the amount you pay in child care expenses. The earned income credit has no effect on the amount you can contribute under the Dependent Care Spending Account for dependent care expenses, and the earned income credit cannot be claimed for any individual for whom you claim the child care credit described above. Moreover, the use of the Dependent Care Spending Account may result in a reduction in your taxable income thus qualifying you for the earned income credit where you would not otherwise have qualified.

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.

According to IRS rules, any amounts remaining in your spending account after the deadline for submitting claims for the Plan Year will be forfeited. You may not carry forward unused amounts to the next Plan Year, and you may not transfer unused amounts from the Dependent Care Spending Account to another employee or to another plan or account (such as the Health Care Spending Account). Therefore, you should plan carefully before you make your annual contribution election. Any forfeited amounts are used by American Water to reduce future administrative expenses.

Expenses Eligible for Reimbursement

The following expenses may be reimbursed so that you, the employee (and your spouse, if you are married), can work or look for work. There is an exception to this rule if you or your spouse work part-time and the payment for care must be made on a periodic (for example, weekly or monthly) basis, In this case, expenses for both work and non-work days are eligible. If payment is made on a daily basis, expenses must be allocated between work and non-work days. Similarly, if you or your spouse are not working due to illness, and you must pay for care on a periodic basis, expenses for nonwork days are eligible if the absence is considered short and temporary.

Expenses may also be reimbursed so that your spouse can attend school full-time or if your spouse is physically or mentally unable to care for himself or herself.

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 Identification number of the provider must be submitted.

- Qualified child or adult day care center expenses (if the center provides care for more than six non-resident persons, the center must meet state or local regulations and receives a fee for such services, whether or not for profit).
- Before-school care, after-school care, or extended day programs (supervised activities for children after the regular school program) if used to enable the employee and spouse to work.
- A babysitter or companion inside or outside the home.
- A housekeeper, nanny, or au pair to the extent the expenses are for the care of a qualifying individual.
- A relative (who is not your dependent nor your child under age 19) who cares for a dependent.
- Someone who cares for an elderly or disabled dependent in your home.
- Nursery school or pre-kindergarten.
- Agency, application, deposit, or other registration fees if necessary to obtain the related care. Fees should not be reimbursed until care is provided, and fees that are forfeited (for example, because the employee selects a different provider) do not qualify.
- Custodial expenses for a dependent over age 13, not attributable to medical services, provided the qualifying individual spends at least eight hours each day in your home.
- Summer day camp tuition (including specialty camp) or a similar program to care for a qualifying individual. Separate equipment or similar charges (e.g., a laptop rental fee) do not qualify.

- FICA and FUTA taxes of day care provider, as long as the overall expenses of the care provider qualify.
- Late fees charged to care for the child because the child was picked up late. Late fees charged because the childcare bill was paid late do not qualify.
- Sick-child facility expenses (care to enable the employee to go to work when the child is ill).
- Transportation costs to and from the location where the care or program is provided, if the expense is part of the cost of the program.

Expenses Not Eligible for Reimbursement

Expenses ineligible for reimbursement include the following:

- Payments for babysitters when you are not working, such as in the evening or on weekends.
- Private school tuition (except before-school and after-school care).
- Educational expenses for children in kindergarten or higher.
- Boarding school tuition.
- Overnight camp expenses.
- 24-hour-a-day nursing home expenses.
- Transportation costs to and from the location where the care or program is provided, unless the expense is part of the cost of the program.
- Expenses for food, clothing, education, or entertainment incurred for the normal care of an eligible dependent, unless these expenses are incidental and cannot be separated from the cost of care.
- Cost for care that enables your spouse to do volunteer work.

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.

Can I Change the Amount of My Contributions?

You can start, stop, or change the automatic deductions from your paycheck during the calendar year if there is a change in your dependent care provider, if there is a change in the cost of dependent or if your dependent no longer meets the definition of qualifying individual. Here are some examples of situations in which you can change your election:

- Change from one childcare center to another and the new center charges a different rate.

- Change in a home childcare provider, including a change in a nanny-sharing arrangement.
- A qualifying child reaches age 13 and is no longer an eligible dependent under the Dependent Care Spending Account.
- The employee marries and the new spouse has dependent children, increasing dependent care costs.
- Child of divorced parents switches residence between parents.

Submitting Claims

You may be reimbursed from your Dependent Care Spending Account by completing a Claim for Reimbursement form, which can be downloaded from www.horizon-healthcare.com/fsa. You must submit the form along with proof of payment for the services (such as receipts, statements, canceled checks, etc.).

Any itemized bills that you submit should contain, at a minimum, the following information

- 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.

Sign and date the claim form. Attach copies of bills, invoices, or other written statements from a third party that support each reimbursement request and mail or fax to:

Horizon Healthcare
3 Penn Plaza East PP-05S
Newark, NJ 07105-2200
Fax: (973) 466-6499 or (973) 274-2215

Remember that you are entitled to reimbursement only *after* the care has been provided, even if you pay for dependent care in advance.

You will receive an Explanation of Payment (EOP) statement from Horizon 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 (FMLA Leave) from American Water, your pre-tax 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 terminate or retire from American Water, your pre-tax payroll deductions to the Dependent Care Spending Account will stop. You may 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.

Disability Coverage (Sick Leave, STD, and LTD)

Disability Benefits

Disability benefits provide income protection when you are unable to work because of an extended illness or injury. American Water provides you with paid sick leave, short-term disability (STD), and long-term disability (LTD) benefits – at no cost to you.

You are eligible for disability benefits (sick leave, STD, and LTD) if you area full-time eligible employee (see "Eligibility" above). Part time employees and temporary employees are not eligible, unless specified by state laws.

Your eligibility date is first day of the month following completion of one full month of continuous service, 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 or an increase in coverage will begin on the day you return to active full-time work for one full day.

The table below summarizes the Plan's disability benefits.

Sick Leave Policy

Effective July 1, 2001, all then-current employees were eligible to bank their sick leave under the existing policy effective June 30, 2001. Every employee is eligible for 2 weeks of sick leave per calendar year. Employees must use their two weeks of annual sick leave before having to access sick time in their bank. The sick leave bank (which pays 100% of pay) must be used before receiving short-term disability (which pays only 75% of pay). However, the sick time and short-term disability run concurrently; therefore, if you have used 15 weeks of sick time, only 11 weeks of short-term disability remain. Once the bank has been exhausted, it will not be reinstated. Unused sick days cannot be carried over into the next calendar year. Unused sick leave will not be paid out upon termination of severance.

Short Term Disability Insurance Benefits

If you are still disabled after your 2 weeks of paid sick leave and sick bank, STD coverage will start paying benefits. You will receive 75% of your base pay each week for 24 weeks (unless superseded by state law), for a combined duration of 26 weeks of payments.

A "disability absence" is time lost from work because of a non-occupational injury or illness which started while you were covered under this Plan.

Note: Short Term Disability does not begin until you have used your 2 weeks of sick leave and all accumulated banked sick time.

Example: Tony has completed 10 years of service as of June 30, 2001. This entitles him to 10 weeks of banked sick leave. On June 30, 2006, he suffers an illness that lasts 15 weeks.

- For the first 2 weeks, Tony will use his 2 weeks of sick leave at 100% of base pay.
- For the next 10 weeks, Tony will use his sick leave bank at 100% of base pay.
- For the next 3 weeks, Tony will receive 75% of his base pay under the STD plan.
- If Tony's disability lasts more than 26 weeks, he would start to receive LTD benefits of 60% of his base pay for as long as he remained disabled.

Sick Leave	2 weeks at 100% of pay each year
Sick Bank (if available)	100% of pay if you have banked sick leave remaining
Short-Term Disability (STD)	75% of base pay, which ends when Sick Leave, Sick Bank, and STD equal 26 weeks combined
Long-Term Disability (LTD) BEGINS AFTER 26 WEEKS	• 100% of pay for any unused banked sick leave in excess of 24 weeks • 100% of pay for unused eligible vacation time • 60% of base pay (up to $15,000 benefit per month), with offsets, to age 65, as long as you remain disabled

If your banked sick leave exceeds 26 weeks, you will continue to receive 100% of base pay until your sick leave is exhausted. Even though LTD benefits begin after 26 weeks, they are offset by your banked sick leave. Since you will already be receiving 100% of pay

from American Water, you will not receive an additional check for LTD benefits (but your period of disability will be running). When your banked sick leave is exhausted, you have the option of taking any unused eligible vacation time, which will extend your 100% of pay.

Your benefit amount will be reduced by any weekly amount for which you are eligible under any Workers' Compensation or similar law that pays you for time lost from work.

Benefits start on Day 8 of a disability due to illness, including pregnancy, and on Day 1 of a disability due to injury. You must report your case to Aetna Managed Disability at (800) 804-5329 if you are (or expect to be) absent from work for more than 5 consecutive workdays. Even if you are receiving 100% of pay, **you must register your disability with Aetna.** You will not be eligible for STD benefits for any period of time in which you are eligible to receive paid sick leave, and the combination of paid sick leave, vacation, and STD benefits will not exceed 26 weeks.

You must provide a doctor's certification that you are disabled because of the specific condition. Aetna may request any additional evidence it believes is necessary before deciding that benefits are payable.

More than one disability absence will be 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 2 consecutive weeks of full-time work.

Your Maximum Period of Payment starts over 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.

STD Benefit Limitations

No benefits are payable for:

- Days on which you do work for pay or profit.
- Any period of time you are not under a doctor's care. You must have been seen in person and treated by a doctor 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. 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 concurrently with sick leave

Submitting STD Claims

To apply for benefits under the Short Term Disability Plan, contact Aetna Managed Disability at **(800) 804-5329**.

To receive disability benefits, you must file a claim within 31 days of your disability. Even if you are using sick time, **you must register your disability with Aetna.** Benefits will begin as soon as Aetna receives the information to verify your disability.

While you are receiving STD benefits, you may be required to periodically provide Aetna with additional medical information from your doctor documenting your continued disability. Aetna may also require that an appointed doctor examine you in order to verify your disability.

It is your responsibility to provide Aetna with the requested documentation supporting your claim. Otherwise, your benefits will stop.

Long Term Disability (LTD) Benefits

If you remain disabled after exhausting your paid sick leave and STD benefits, you are eligible to receive LTD benefits. You will receive a scheduled monthly benefit equal to a percentage of your pre-disability earnings.

The Waiting Period before LTD benefits begin is the greater of:

Waiting Period

- The first 26 weeks of a period of disability; and
- The period of time when disability benefits are payable from any short-term disability benefits or salary continuation program sponsored by your Employer. This could occur if banked sick time exceeds 26 weeks.

If you are unable to earn more than 80% of your adjusted predisability earnings solely due to disease or injury, you will not be deemed to have performed the material duties of your own occupation on that day.

Scheduled Monthly Benefit

The monthly LTD benefit is 60% of your monthly predisability earnings. Benefits will be reduced by “other income benefits,” as described on page 145.

The maximum monthly LTD benefit is $15,000.

Total Disability

For purposes of receiving LTD benefits, you are deemed to be totally disabled while either of the following applies to you:

- In the first 24 months of a period of disability:

  You are unable, solely because of injury or disease, to perform the material duties of your own occupation. If you start work at a reasonable occupation, you will no longer be deemed totally disabled.

- After the first 24 months of a period of disability:

  You are unable, solely because of injury or disease, to work at any reasonable occupation.

You will not be deemed to be performing the material duties of your own occupation or working at a reasonable occupation on any day if:

- You are performing at least one (but not all) of the material duties of your own occupation or you are working at any occupation (full-time or part-time); and
- Solely due to disease or injury, your income from either your own occupation or any occupation is 80% or less of your adjusted predisability earnings.

“Reasonable occupation” is any gainful activity for which you are, or may reasonably become, suited because of your education, training, or experience. It does not include work under an Approved

Rehabilitation Program. This determination will be made by Aetna in its sole discretion.

When Disability Period Begins

A period of "total disability" begins on the first day you are totally disabled as a direct result of a significant change in your physical or mental condition that happens while you are covered under this Plan.

You must be under the care of a doctor. (You will not be deemed to be under the care of a doctor on any given day unless your doctor has seen and treated you in person for the disease or injury that caused the total disability in the prior 31-day period.)

When Disability Period Ends

Your period of total disability ends on the first to occur of:

- The date you are not totally disabled.
- The date you start work at a reasonable occupation.
- The date you fail to give proof that you are still totally disabled.
- The date you refuse to be examined.
- The date you cease to be under a doctor's care.
- The expiration date of the Maximum Benefit Duration shown on the Summary of Coverage.
- The date you are not undergoing effective treatment for alcoholism or drug abuse, if your disability is caused to any extent by alcoholism or drug abuse.
- The date you have income from any employer or from any occupation for compensation or profit equal to more than 80% of your adjusted predisability earnings.
- The date you fail to give proof that you are unable to perform the duties of any occupation for compensation or profit equal to more than 80% of your adjusted predisability earnings.
- The date of your death.
- The day after Aetna determines you are able to participate in an Approved Rehabilitation Program and you refuse to do so.

Also, a period of total disability will end after 24 monthly benefits are payable if it is determined that the disability is, at that time, caused to any extent by a mental condition (including conditions related to alcoholism or drug abuse) described in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (called "DSM"), published by the American Psychiatric Association.

Two exceptions to this rule apply if you are confined as an inpatient in a hospital or treatment facility (see "Types of Facility" on page 156) for that condition at the end of the 24 months.

- If the inpatient confinement lasts less than 30 days, the period of total disability will cease when you are no longer confined.
- If the inpatient confinement lasts 30 days or more, the period of total disability may continue until the date you have not been confined for that condition for a total of 90 days during any 12-month period.

The Separate Periods of Total Disability section below does not apply beyond 24 months to periods of disability that are subject to the above paragraph.

Separate Periods of Disability

Once a period of total disability has ended, any new period of disability will be treated separately.

However, 2 or more separate periods of total disability, due to the same or related causes and separated by less than 6 months, will be deemed to be one period of total disability. Only one waiting period will apply.

Any day on which, solely due to disease or injury, your income is less than or equal to 80% of your adjusted predisability earnings, you will not, on that day, be deemed to be working at:

- your own occupation; or
- any reasonable occupation.

The first period will not be included if it began while you were not covered under this LTD Plan.

Other Income Benefits

Other Income Benefits Which Reduce Your Monthly LTD Benefit

Other income benefits are:

- 50% of any award provided under The Jones Act or The Maritime Doctrine of Maintenance, Wages and Cure.
- Disability, retirement, or unemployment benefits required or provided for under any law of a government. Examples are:
  - Unemployment compensation benefits.

- Temporary or permanent, partial or total disability benefits under any state or federal workers' compensation law or any similar law, which are meant to compensate the worker for any one or more of the following: loss of past and future wages; impaired earning capacity; lessened ability to compete in the open labor market; any degree of permanent impairment; and any degree of loss of bodily function or capacity.
- Automobile no-fault wage replacement benefits to the extent required by law.
- Statutory disability benefits.
- Benefits under the Federal Social Security Act, the Railroad Retirement Act, the Canada Pension Plan, and the Quebec Pension Plan.
- Veterans' benefits.

- Disability or unemployment benefits under:
  - any group insurance plan.
  - any other type of coverage for persons in a group. This includes both plans that are insured and those that are not.
- Full retirement benefits for which you are or may become eligible under a group pension plan at the later of age 62 and the plan's normal retirement date, but only to the extent that such benefits were paid for by an employer.
- Retirement benefits received under any group pension plan, but only to the extent that such benefits were paid for by an employer.
- Disability payments that result from the act or omission of any person whose action caused your disability. These payments may be from insurance or other sources.
- Disability benefits under any group mortgage or group credit disability plan.

Other income benefits include those payable to you, your spouse, your children, or your dependents, due to your disability or retirement.

Increases in the level of “other income benefits” due to the following **will reduce** your monthly LTD benefits:

- a change in the number of your family members;
- a recomputation or recalculation to correct or adjust your benefit level as first established for the period of total disability; or
- a change in the severity of your disability.

Effect of Cost-of-Living Increases

Cost-of-living increases in the level of other income benefits received from a governmental source during a period of total disability **will not reduce** your monthly LTD benefits.

Cost-of-living or general increases in the level of other income benefits from a **non**-governmental source during a period of total disability **will not reduce** your monthly LTD benefits to the extent they are based on the annual average increase in the Consumer Price Index.

Increases in Other Income Benefits Which Do Not Reduce Your Monthly Benefit

The amount of any retirement or disability benefits you were receiving from the following sources before the date you become disabled under this LTD Plan **will not reduce** your monthly benefits:

- a military and other government service pensions;
- retirement benefits from a prior employer; and
- veterans' benefits for service related disabilities.

The amount of any income or other benefits you receive from the following sources **will not reduce** your monthly benefits:

- profit-sharing plans,
- thrift plans,
- 401(k) plans,
- Keogh plans,
- employee stock option plans, or
- tax sheltered annuity plans.

Predisability Earnings

This is the amount of salary or wages you were receiving from American Water on the day before a period of disability started, calculated on a monthly basis.

It will be figured from whichever rule below applies to you:

- If you are paid on an annual basis, your monthly salary is 1/12th of your annual salary.
- If you are paid on an hourly basis, the calculation of your monthly wages is based on your hourly pay rate multiplied by the number of hours you are regularly scheduled to work per month; but not more than 173 hours per month.
- If you do not have regular work hours, the calculation of your monthly salary or wages is based on the average number of hours you worked per month during the last 12 calendar months (or

during your period of employment if fewer than 12 months); but not more that 173 hours per month.

What's Included in Salary or Wages

Included in salary or wages are:

- Pre-tax contributions you make under the Medical Plan, Dental Plan, Vision Plan, Health Care Spending Account or Dependent Care Spending Account
- Salary deferrals you make under an American Water 401(k) Plan
- Salary deferrals you make under an executive nonqualified deferred compensation agreement

What's Not Included in Salary or Wages

Not included in salary or wages are:

- Awards and bonuses
- Overtime pay
- Contributions made by the Company to any deferred compensation arrangement or pension plan

A retroactive change in your rate of earnings will not result in a retroactive change in coverage.

Benefit Adjustment During Return to Work

If, while monthly benefits are payable, you have income from:

- any employer, or
- any occupation for compensation or profit,

which is more than 20% of your adjusted predisability earnings; the monthly benefit as figured above will be adjusted as follows:

- During the first 12 months that you have such income, the monthly benefit will be reduced only to the extent the amount of that income and the monthly benefit payable, as figured above, exceeds 100% of your adjusted predisability earnings.
- Thereafter, the monthly benefit will be the product of the following:

  (A divided by B) x C where:

  A = Your adjusted predisability earnings minus such income.
  B = Your adjusted predisability earnings.
  C = The monthly benefit figured without regard to this paragraph.

In figuring the monthly benefit, other income benefits do not include income from any employer or income from any occupation for compensation or profit.

Maximum Benefit Duration

Your period of disability will end as follows (unless it ends earlier for one or more of the reasons stated elsewhere in this booklet):

- If your period of total disability starts before your 62nd birthday, it will end with the calendar month in which you reach age 65.
- If your period of total disability starts on or after your 62nd birthday, it will end when the number of months of total disability expire (after the waiting period is met) as figured from the following schedule:

Maximum Benefit Duration Schedule

Age When Period of Total Disability Starts	Months of Total Disability
62 but less than 63	42 months
63 but less than 64	36 months
64 but less than 65	30 months
65 but less than 66	24 months
66 but less than 67	21 months
67 but less than 68	18 months
68 but less than 69	15 months
69 and over	12 months

Pregnancy Coverage

Benefits are payable on the same basis as for a disease if a female employee, while covered under this Plan, is absent from active work

because of a totally disabling pregnancy-related condition. A doctor must certify in writing that the employee is totally disabled because of the condition. Further, Aetna may request additional evidence before deciding that benefits are payable.

If, during the 3 months before coverage began, services are provided or supplies are received in connection with a pregnancy or a pregnancy is confirmed, the pregnancy is a preexisting condition whether or not the pregnancy commenced during that 3-month period.

Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the plan document on file with your Employer. Any increase is subject to any Active Work Rule described in Effective Date of Coverage section of this Summary of Coverage.

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.

Limitations That Apply to Long Term Disability Coverage

Long Term Disability Coverage does not cover any disability that:

- Is due to intentionally self-inflicted injury (while sane or insane).
- Results from your commission of, or attempting to commit, an assault, battery, or felony.
- Is due to war or any act of war (declared or not declared).
- Is due to: insurrection; rebellion; or taking part in a riot or civil commotion.
- Starts during the first 12 months of your current Long Term Disability Coverage, if it is caused or contributed to by a "preexisting condition." A disease or injury is a preexisting

condition if, during the 3 months before the date you last became covered:

– it was diagnosed or treated; or

– services were received for the disease or injury; or

– you took drugs or medicines prescribed or recommended by a doctor for that condition.

In the case of pregnancy, see “Pregnancy Coverage” above for rules.

On any day during a period of disability that a person is confined in a penal or correctional institution for conviction of a criminal or other public offense, the person will not be deemed to be totally disabled; and no benefits will be payable.

When LTD Coverage Ends

LTD coverage ends at the first to occur of:

- When employment ceases,
- When the group contract terminates as to the coverage,
- When you are no longer an eligible employee. (See "Eligibility" above.)

Ceasing active work will be deemed to be cessation of employment. If you are not at work due to one of the following, employment may be deemed to continue up to the limits shown below.

- If you are not at work due to disease or injury, your employment may be continued until stopped by your Employer, but not beyond 12 months from the start of the absence.
- If you are not at work due to temporary lay-off or leave of absence, your employment will be deemed to cease on your last full day of active work before the start of the lay-off or leave of absence.

Coverage After Termination

If your coverage ends during a period of total disability which began while you had coverage, benefits will be available as long as your period of total disability continues.

Survivor Benefit

If you die while totally disabled, the LTD plan will pay a single, lump sum benefit if there is an Eligible Survivor as defined below.

The benefit amount will be:

- 3 times the Monthly Benefit, not reduced by other income benefits, for which you were eligible in the full month just before the month in which you die.

If you die before you are eligible for one full Monthly Benefit, however, the benefit will be:

- 3 times the Monthly Benefit, not reduced by other income benefits, for which you would have been eligible if you had not died, for the first full month after the month in which you die.

Eligible Survivor

An Eligible Survivor is:

- Your legally married spouse at the date of your death.
- If there is no such spouse, your biological or legally adopted child who, when you die:
  - is not married; and
  - is depending mainly on you for support; and
  - is under age 25. This age limit will not apply if the child is not capable of self-sustaining employment because of mental or physical handicap which existed before age 25.

Payment of Survivor Benefits

The benefit will be paid as soon as the necessary written proof of your death and total disability status is received.

- The benefit will be paid to your eligible surviving spouse, if any. Otherwise, it will be paid in equal shares to your eligible surviving children.

Aetna, in its capacity as the provider of administrative services to this Plan, may pay the benefit to anyone who, in Aetna's opinion, is caring for and supporting the eligible survivor; or, if proper claim is made, to an eligible survivor's legally appointed guardian or committee.

Assignment of Insurance

Coverage may be assigned only with the consent of Aetna.

How and When To Report Your LTD Claim

- You are required to submit a claim to Aetna. If Aetna requires that claim forms be submitted, they may be obtained from Aetna. Your claim must give proof of the nature and extent of the loss. Aetna may require copies of documents to support your claim, including data about any other income benefits. You must also provide Aetna with authorizations to allow it to investigate your claim and your eligibility for and the amount of other income benefits.
- You must furnish such true and correct information as Aetna may reasonably request.
- The deadline for filing a claim for benefits is 90 days after the end of the waiting period. If, through no fault of your own, you are unable to meet the deadline for filing a claim, your claim will be accepted if you file as soon as possible; but not later than 1 year after the deadline unless you are legally incapacitated. Otherwise, late claims will not be covered.

Aetna has the right to require proof that:

- you, your spouse, child, or dependent has made application for all other income benefits which you or they are, or may be, eligible to receive relative to your disability and has made a timely appeal of any denial through the highest Administrative level. Timely appeal means making such an appeal as required, but in no case later than 60 days from the latest denial;
- the person has furnished proofs needed to obtain other income benefits;
- the person has not waived any other income benefits without Aetna's written consent; and
- the person has sent copies of documents to Aetna showing the effective dates and the amounts of other income benefits.

Aetna also requires proof:

- of income you receive from any occupation for compensation or profit; and

- if your income from any such occupation is 80% or less of your adjusted predisability earnings, proof that you are unable, due to disease or injury, to earn more than 80% of your adjusted predisability earnings.

In addition to the above, for purposes of Federal Social Security, when a timely application for benefits has been made and denied, a request for reconsideration must be made within 60 days after the denial, unless Aetna states, in writing, that it does not require you to do so. Also, if the reconsideration is denied, an application for a hearing before an Administrative Law Judge must be made within 60 days of that denial unless Aetna relieves you of that obligation.

You do not have to apply for:

- retirement benefits paid only on a reduced basis; or
- disability benefits under group life insurance if they would reduce the amount of group life insurance;

but, if you do apply for and receive these benefits, they will be deemed to be other income benefits for which proof is required.

- If you do not furnish proof of other income benefits, your benefits may be suspended or adjusted by the estimated amount of such other income benefits.

How Benefits Will Be Paid

- Benefits will be paid to you at the end of each calendar month during the period for which benefits are payable. If a monthly benefit would be less than $10, Aetna may make payments less often. They may be made on a quarterly, semi-annual, or annual basis. Benefits for a period less than a month will be prorated. This will be done on the basis of the ratio, to 30 days, of the days of eligibility for benefits during the month.
- Aetna, in its capacity as the provider of administrative services to this Plan, may pay up to $1,000 of any benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or unable to give a valid release. It can also be done if a benefit is payable to your estate.

Examinations and Evaluations

Aetna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while that claim is pending or payable. This will be done at the Plan's expense.

Legal Action

- No legal action can be brought to recover under any benefit after 3 years from the deadline for filing claims.
- Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

Recovery of Overpayments

If payments are made in amounts greater than the benefits that you are entitled to receive, Aetna, in its capacity as the provider of administrative services to this Plan, has the right to do any one or all of the following:

- to require you to return the overpayment on request;
- to stop payment of benefits until the overpayment is recovered;
- to take any legal action needed to recover the overpayment; and
- to place a lien, if not prohibited by law, in the amount of the overpayment on the proceeds of any other income, whether on a periodic or lump sum basis.

Types of Facility

Hospital

This is an institution that:

- mainly provides, on an inpatient basis, diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment, and care of injured and sick persons; and
- is supervised by a staff of doctors; and
- provides 24 hour a day registered nursing (RN) service; and
- is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.

An institution which does not provide complete surgical services, but which meets all the other tests listed above, will also be deemed a hospital if:

- it provides services chiefly to patients all of whom have conditions related either by a medical specialty field or a specific disease category; and
- while confined, the patient is under regular therapeutic treatment by a doctor for the injury or disease.

Treatment Facility

This is an institution (or distinct part thereof) that is for the treatment of alcoholism or drug abuse and which meets fully every one of the following tests:

- It is primarily engaged in providing on a full-time inpatient basis, a program for diagnosis, evaluation, and treatment of alcoholism or drug abuse.
- It provides all medical detoxification services on the premises, 24 hours a day.
- It provides all normal infirmary-level medical services required during the treatment period, whether or not related to the alcoholism or drug abuse, on a 24-hour daily basis. Also, it provides, or has an agreement with a hospital in the area to provide, any other medical services that may be required during the treatment period.
- On a continuous 24-hour daily basis, it is under the supervision of a staff of doctors, and provides skilled nursing services by licensed nursing personnel under the direction of a full-time registered graduate nurse.

- It prepares and maintains a written individual plan of treatment for each patient based on a diagnostic assessment of the patient's medical, psychological, and social needs with documentation that the plan is under the supervision of a doctor.
- It meets any applicable licensing standards established by the jurisdiction in which it is located.

Third Party Liability and Subrogation

General Principle

When you receive disability benefits under the Plan which are related to disabilities for which benefits are payable under Workers' Compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, you or your dependent shall reimburse the Plan for the related benefits received out of any funds or monies you recover from any third party.

Specific Requirements and Plan Rights

Because the Plan is entitled to reimbursement, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that you may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to reimbursement is regardless of the manner in which the recovery is structured or worded, and even if you have not been paid or fully reimbursed for all damages or expenses.

The Plan's share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

The Plan may enforce its subrogation or reimbursement rights by requiring you to assert a claim to any of the benefits to which you may

be entitled. The Plan will not pay attorneys fees or costs associated with the claim or lawsuit without express written authorization from the Employer.

If the Plan should become aware that you have received a third party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to you or any of your dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of you.

Participant Duties and Actions

By participating in the Plan you consent and agree that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, you agree to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Once you have any reason to believe that you may be entitled to recovery from any third party, you must notify the Plan. And, at that time, the you (and your attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle you to any payment, amount or recovery from a third party.

If you fail or refuse to execute the required subrogation/reimbursement agreement, the Plan may deny payment of any benefits to you and any of your dependents until the agreement is signed. Alternatively, if you fail or refuse to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of you, your acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement.

You consent and agree that you shall not assign your rights to settlement or recovery against a third person or party to any other party, including their attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Employer.

Life Insurance

Life Insurance Benefits

American Water helps you provide financial security for your family in the event of your death. You also have coverage in case of a specific accidental injury, or if you die as the result of an accident.

In addition to the coverage provided to you at no cost by American Water, you also have the option of buying supplemental life insurance coverage for you or your eligible dependents.

The following table summarizes the Plan's life insurance benefits:

Basic	1.5 times your base pay (maximum benefit $200,000)
Accidental Death and Dismemberment	1.5 times your base pay (maximum benefit $200,000)
Voluntary	1, 2, or 3 times your base pay (maximum benefit $1,000,000)
Voluntary Dependent	$20,000 (spouse) and $10,000 per dependent child

Eligibility

If you area full-time eligible employee (see "Eligibility" above), you are eligible to participate in American Water Life Insurance Benefit Plans. Your eligibility participation date is 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 or an increase in coverage will begin on the day you return to active work.

Basic Life Insurance

Your Company-paid life insurance amount is equal to 1.5 times your base pay, rounded to the next higher $1,000. The maximum benefit is $200,000.

Your life insurance amount will increase automatically with salary increases. If you are an hourly-paid employee, your life insurance benefit is calculated based on your normally scheduled hours, excluding overtime.

This is an insured plan underwritten by MetLife. The provisions of the Plan will remain effective only while you are covered under the group contract.

Imputed Income

Federal law requires you to pay income taxes on the value of Company-provided group term life insurance coverage on your life (but not voluntary life insurance) that exceeds $50,000. Therefore, you have additional income called "imputed income," and that is included in your annual compensation for income tax withholding and Social Security purposes. You do not actually receive additional income in your paycheck. The imputed income amount is determined by the IRS using age-related rates.

Accelerated Death Benefits

If you (or your spouse, if enrolled in voluntary dependent coverage) become terminally ill while covered under the Life Insurance program, you may request that MetLife 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 generally accepted protocols, will not survive longer than six (6) months.

You may request an Accelerated Death Benefit on your own behalf or on behalf of your spouse (if enrolled in voluntary dependent coverage) at any time by completing a MetLife Request for Accelerated Death Benefit Form and submitting it to MetLife. The request must include

the statement of a currently licensed United States doctor that you or your spouse is terminally ill.

The doctor's statement must include:

- all medical test results,
- laboratory reports, and
- any other information on which the statement is based, including the generally accepted protocols used by the doctor 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 $100,000 of Basic Life Insurance and $300,000 of Voluntary Life Insurance.

This benefit can be requested only once on your own behalf and once for your spouse. If someone other than you owns the 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 month of your 70th birthday will be reduced by 35% at age 70; 60% at age 75; and 75% at age 80.

If you become insured during or after the month in which you reach the above ages (70, 75, or 80), your Life Insurance amount will be the applicable percentage of the amount shown for your classification.

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 Life Insurance ceases. If you die during this 31-day period 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 and Voluntary life insurance.

Conversion of Your Life Insurance

If any of your life insurance ceases because your employment ends or you are no longer in a class eligible for that insurance, or because of age, pension, or retirement, you may convert the amount of insurance which ends (or a lesser amount, if desired) to an individual policy. This applies to Basic and Voluntary life insurance.

Your converted policy may be any kind of individual policy then customarily being issued by MetLife 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 ends because that part of the group contract discontinues as to your employee class, and your insurance has been in force under the group contract for at least five years in a row before it was discontinued, you may convert the amount that ends (minus the amount of any group life insurance for which you become eligible within 31 days of discontinuance) to an individual policy. The maximum amount that can be converted by each person in any event is $10,000.

Applying for an Individual Policy

In order to convert, you must make written application for an individual policy and pay the first premium within 31 days after insurance ends for any of the above reasons. No evidence of insurability (that is, proof of good health) 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 MetLife'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 life insurance ceases. If you die during this 31-day period 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 of the person's prior coverage, the rules below apply to that part.

"Prior coverage" is any plan of group insurance sponsored by American Water that has been replaced by coverage under part or all of this Plan. 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 become entitled to a claim under the prior life insurance, your Life Insurance under this Plan will be canceled as of its effective date and any premiums paid for your life insurance under this Plan will be returned to American Water

The mode of settlement you chose and the beneficiary you named under a prior MetLife plan will apply to this Plan. This can be changed according to the terms of this Plan.

Voluntary Life Insurance

Voluntary Coverage for You

In addition to Company-paid life insurance, you can buy supplemental life insurance coverage for you or your eligible dependents on an after-tax basis.

You can buy life insurance of one, two, or three times your base pay, up to a maximum benefit of $1,000,000. You must be actively at work in order for coverage to take effect.

If you want to buy coverage over $300,000 at this initial offering, you will be required to show proof of good health. You will be enrolled in the level that does not exceed $300,000 until proof of good health is approved by MetLife. If you do not elect supplemental coverage at the initial offering, proof of good health will be required for *any* amount of coverage.

Note: You will be required to show proof of good health if you:

- Did not enroll previously for coverage,
- Elect coverage over $300,000,
- Elect more than one times your current voluntary supplemental life insurance coverage amount.

If proof of good health is required, your election will be pended until you receive approval from MetLife.

Voluntary Coverage for Your Dependents

You can also buy supplemental 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.

Cost

The following table shows the premiums for voluntary supplemental life insurance:

Voluntary Supplemental Life Insurance Premiums (per $1,000 of base pay)			
Age	**Monthly Cost**	**Age**	**Monthly Cost**
Under 30	$0.06	50-54	$0.32
30 – 34	$0.08	55-59	$0.59
35 – 39	$0.10	60-64	$0.75
40 – 44	$0.12	65-69	$1.37
45 – 49	$0.19	70 and over	$2.21

The following table shows the premiums for voluntary spouse and dependent life insurance:

Voluntary Spouse and Dependent Life Insurance Premiums	
Spouse	$5.00 per month
Dependent Child(ren)	$1.20 per month per family

Optional Employee Group Term Life Insurance

Participation Frozen as of December 31, 1995

Participation in the current Optional Employee Group Term Life Insurance program 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 while you remain actively employed. 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.

The 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. This benefit will end upon retirement or termination, but can be converted to an individual policy.

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

Beneficiaries

When you elect to participate in any of these Plans, you need to designate a Beneficiary (or beneficiaries) to receive life insurance benefits if you die.

You may name or change your beneficiary by submitting a Beneficiary Designation Form, which is available from the Benefits Service Center. The naming or any change will take effect on the date the Benefits Center receives your completed Beneficiary Designation Form.

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 you have no spouse, in equal shares to your children.
- If you have no spouse or child, to your parents, equally or to the survivor.
- If you have 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 a Permanent and Total Disability 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 first become permanently and totally disabled.
- You must furnish all proof when requested. MetLife has the right to examine you, at its expense, before approving the proof.

Waiver

If you are under age 60 and you are permanently and totally disabled while insured under the Plan (meaning you can do no work for pay or profit) and you furnish all information, notices, and proof when required, the amount of your life insurance in force on your last day actively at work may be extended during the disability, without payment of premiums and contributions. The duration, nature, and extent of disability determine eligibility for this extension. This insurance benefit reduces to $10,000 when you reach age 70.

Any total disability should be reported immediately to American Water 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.

Application for Waiver of Premium should be filed after your 8th month of disability but **before** the end of the 12th full month of disability. For example, if your first day of absence from work due to disability was February 15, 2006, the application should be filed after October 15, 2006 but **before** February 14, 2007. Your local HR representative will initiate the process by sending you the application and instructions. You will then be required to forward the completed application and any required documentation to MetLife. Please contact your HR representative if you have any questions or concerns.

Extended Death Benefit

If MetLife 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 stop 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 cease.
- You would have qualified for the Permanent and Total Disability benefit except that:
  - your total disability did not last at least six months, or
  - the required proof was not yet received or approved by MetLife.

Written notice of your death must be given to MetLife at its Home Office within 12 months of your death. If it is not given, MetLife will not have to pay this benefit.

When MetLife approves a claim for any benefit under this feature, the benefit will be in full settlement and satisfaction of MetLife'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 plan is an insured plan underwritten by MetLife. The provisions of the Plan will remain effective only while you are covered under the group contract.

Your Company-paid AD&D Insurance pays 1.5 times your base pay, rounded to the next higher $1,000, up to a maximum benefit of $200,000 (called the "Principal Sum"). The following must occur for benefits to become payable: while insured, you suffer a bodily injury in an accident and, within 90 days after the accident and as a direct result of the injury:

- You die.
- You lose a hand, at or above the wrist joint.
- You lose a foot, at or above the ankle joint.
- You suffer the irrecoverable and complete loss of sight in the eye.
- Your full Principal Sum is payable if you die. Half your Principal Sum is payable if you lose a hand, foot, or eye. No more than the Principal Sum 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 Basic Life Insurance Plan, Optional Employee Group Term Life Plan, or Voluntary Life Insurance Plan, your beneficiary must complete and submit the appropriate Statement of Claim form and provide a certified death certificate to the Benefits Service Center within one year of the death.

If you were totally disabled at the time of your death and American Water 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 the Benefits Service Center 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 benefits are paid in a lump sum. However, other payment options may be available from MetLife. The Benefits Service Center will provide information about optional payment methods when you or your beneficiary are eligible to receive benefits.

Employee Assistance Program (EAP)

Employee Assistance Program

The Employee Assistance Program (EAP), run by Carebridge, provides the support you need to deal with the variety of challenges you may face – financial, legal, family, emotional, etc. All EAP services are free and confidential for you and your dependents.

Carebridge also provides a Website www.myliferesource.com, which puts a wealth of resources right at your fingertips. The Universal LifeHelps Library is one of the most extensive resources on the Web with over 1,474 Resource Centers centered on the five major areas of modern life: Myself, My Relationships, My Daily Life Concerns, My Wellness and My Work. In addition, you will have access to legal documents and help finding service providers (e.g., childcare locations). You can visit the new, improved Carebridge Web site at www.myliferesource.com. When visiting for the first time, enter the American Water organization code (HXSBJ) to register for your account.

You don't have to access the Internet to benefit from Carebridge services. You can contact an EAP counselor by phone 24 hours a day, seven days a week at 1-800-437-0911.

Additional Plan Information

Additional Plan Information

- **Plan Sponsor**

  American Water Works Company, Inc.
  1025 Laurel Oak Road
  Voorhees, NJ 08043

- **Plan Name** – Group Insurance Plan of American Water Works Company, Inc. and Designated Subsidiaries and Affiliates

- **Employer Identification Number** – 51-0063696

- **Plan Number** – 501

- **Effective Date of this Summary Plan Description**

  January 1, 2006

- **Plan Year**

  January 1 through December 31st

- **Type of Plan**

  Health and Welfare Benefit Plan, providing the following benefits: medical, dental, prescription, vision, disability, life and accident insurance and flexible spending accounts. The medical, dental, prescription, vision and health care spending account are provided under a "group health plan" within the meaning of federal law.

- **Type of Administration**

  Self-Insured/Administrative Services Contract/Fully Insured

- **Plan Administrator**

  Senior Vice President, Human Resources
  American Water
  1025 Laurel Oak Road
  Voorhees, NJ 08043
  (856) 346-8200

- **Agent for Service of Legal Process**

  The Secretary
  American Water
  1025 Laurel Oak Road
  Voorhees, NJ 08043
  (856) 346-8200

- **Source of Contributions**

  Employer and Employee

- **Appeals Administrator**

  Retirement / Benefits Committee
  American Water
  1025 Laurel Oak Road
  Voorhees, NJ 08043
  (856) 346-8200

Plan Notices

Medicare Part D Notice

If you are actively at work at age 65 or older and then you retire and become Medicare-eligible, you must call the Benefits Service Center to request a Notice of Creditable Coverage to avoid the Medicare Part D late enrollment fee.

Medicare Part B Enrollment

The following information comes from http://questions.medicare.gov, The Official U.S. Government Site for People with Medicare.

Can I delay Medicare Part B enrollment without paying higher premiums?
Yes. In certain cases, you can delay your Medicare Part B enrollment without having to pay higher premiums. If you didn't take Medicare Part B when you were first eligible because you or your spouse were working and had group health plan coverage through your or your spouse's employer or union, you can sign up for Medicare Part B during a Special Enrollment Period. You can sign up:

- Anytime you are still covered by the employer or union group health plan through your or your spouse's current or active employment, or
- During the 8 months following the month the employer or union group health plan coverage ends or when the employment ends (whichever is first).

If you are disabled and working (or you have coverage from a working family member), the Special Enrollment Period rules also apply.

Effective date if you sign up during a Special Enrollment Period
If you enroll in Medicare Part B while covered by the group health plan or during the first full month after coverage ends, your Medicare Part B coverage starts on the first day of the month you enroll. You also can delay the start date for Medicare Part B coverage until the first day of any of the following 3 months.

If you enroll during any of the 7 remaining months of the Special Enrollment Period, your Medicare Part B coverage begins the month after you enroll.

Remember: If you do not enroll in Medicare Part B during your Special Enrollment Period, you'll have to wait until the next General Enrollment Period, which is January 1 through March 31 of each year. You may then have to pay a higher Medicare Part B premium because you could have had Medicare Part B and did not take it. Call the Social Security Administration at (800) 772-1213 for more information or to enroll in Medicare. You can visit the Social Security web site at www.socialsecurity.gov.

Amendment or Termination of the Plan

The Right to Amend or Terminate the Plan

American Water reserves the right to amend all or any of our employee benefit plans at any time, without prior notice to participants, including the right to change eligibility criteria or program costs and the right to restrict or eliminate benefits provided. The decision to change or end the plans may be caused by changes in federal or state laws governing benefits, the requirements of the Internal Revenue Code or ERISA, or any other reason.

The authority to make any such changes to the Plan generally rests with the Board of Directors of American Water or its designee, 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.

You will be notified if any material changes are made to the Plan or if it is terminated. No amendment, termination, or partial termination of the Plan will affect claims incurred for which items or services have been provided before the date of amendment, termination, or partial termination

Filing a Claim

The claim-filing procedures for each type of benefit are outlined in the individual sections describing the benefits. In general, you and your eligible dependents or designated beneficiary (when applicable) must file a written claim on the proper form. You can obtain the necessary claim forms from your Benefits Service Center.

Claim Determination and Appeals Process

The contracts, booklets, and other materials that describe a particular benefit under the Plan will generally contain a specific set of claims and appeals procedures that you must follow to make a claim to receive that particular benefit and/or to appeal a denied claim for that particular benefit. Although these separate claims and appeals procedures will be very similar in most respects, there may be important differences. Because of this, you should follow the specific claims and appeals procedures for a particular benefit very carefully. If the booklets and other materials that describe a particular benefit do not contain a specific set of claims and appeals procedures, the Plan's default procedures as described below will apply. If you have any questions about which set of claims and appeals procedures to follow or any other questions about making a claim, you should contact the Plan Administrator immediately.

For purposes of this section of the SPD describing the Plan's default claims and appeals procedures, the third parties to whom the Plan Administrator has delegated the authority to review and evaluate claims (in the case of the self-insured plans) and the insurance carriers (in the case of the insured plans) shall be referred to as the "Claims Administrator" at the initial claim level and the "Appeals Administrator" at the appeal level.

A request for benefits is a "claim" subject to these procedures only if you or your authorized representative file it in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing (except urgent care claims, which may be made orally) with the applicable provider. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim) must be filed with the Plan Administrator at the address set forth in the "Additional Information" section on page 175. A request for prior approval of a benefit or service where prior approval is not required

under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim. If a claim is received but there is not enough information to allow the Claims Administrator to process the claim, you will be given an opportunity to provide the missing information.

If you want to bring a claim for benefits under the Plan, you may designate an authorized representative to act on your behalf as long as you provide written notice of such designation to the Claims Administrator and/or the Appeals Administrator identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional with knowledge of your medical condition may act as your authorized representative with or without prior notice.

Claims Not Involving Health Benefits

In the case of a claim not involving health benefits (e.g., Life, AD&D, LTD, STD and Dependent Care Spending Account), initial claims for benefits under the Plan should be made by you in writing to the Claims Administrator.

Time Periods for Responding to Initial Claims

If you bring a claim for benefits under the Plan, the Claims Administrator will respond to you within 90 days (45 days for a claim involving disability benefits) after receipt of the claim. For claims not involving disability benefits, if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 90-day period that up to an additional 90 days is needed to review your claim. In the case of a claim involving disability benefits, the Claims Administrator will notify you within the initial 45-day period that up to an additional 30 days is needed to review your claim. If the Claims Administrator determines that additional time is necessary to review your claim for disability benefits, the Claims Administrator may notify you of an additional 30-day extension.

Notice and Information Contained in Notice Denying Initial Claim

If the Claims Administrator denies your claim (in whole or in part), the Claims Administrator will provide you with written notice of the denial. This notice will include the following:

- Reason for the denial - the specific reason or reasons for the denial;
- Reference to Plan provisions - reference to the specific Plan provisions on which the denial is based;

- Description of additional material - a description of any additional material or information necessary for you to perfect your claim and an explanation as to why such information is necessary;
- Description of any internal rules - in the case of any claim involving disability benefits, a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the determination and that a copy of such rule will be provided to you free of charge at your request; and
- Description of claims appeals procedures - a description of the Plan's appeals procedures and the time limits applicable for such procedures, including a statement that you are eligible to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal.

Appealing a Denied Claim for Benefits

If the Claims Administrator denies your initial claim for benefits, you may appeal the denial by filing a written request with the Appeals Administrator within 60 days (180 days in the case of a claim involving disability benefits) after you receive the notice denying your initial claim for benefits. If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) to the Appeals Administrator for review and consideration. You will also be entitled to receive, upon request and free of charge, access to, and copies of all documents, records, and other information relevant to your appeal.

Time Periods for Responding to Appealed Claims

If you appeal a denied claim for benefits under the Plan, the Appeals Administrator will respond to you within 60 days (45 days in the case of a claim involving disability benefits) after receipt of the claim. If the Appeals Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Appeals Administrator will notify you within the initial 60-day period (the initial 45-day period in the case of a claim involving disability benefits) that up to an additional 60 days (45 days in the case of a claim involving disability benefits) is needed to review your claim.

Notice and Information Contained in Notice Denying Appeal

If the Appeals Administrator denies your claim (in whole or in part), the Appeals Administrator will provide you with written notice of the denial. This notice will include the following:

- Reason for the denial - the specific reason or reasons for the denial;

- Reference to Plan provisions - reference to the specific Plan provisions on which the denial is based;
- Statement of entitlement to documents - a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your claim and/or appeal for benefits;
- Description of any internal rules - in the case of a claim involving disability benefits, a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the appeal determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
- Statement of right to bring action - a statement that you are entitled to bring a civil action in Federal court under Section 502 of ERISA to pursue your claim for benefits.

The decision of the Appeals Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If you challenge the decision of the Appeals Administrator, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before you can pursue the claim in Federal court. Facts and evidence that become known to you after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

Claims Involving Health Benefits

In the case of a claim involving health benefits (e.g., Medical, Dental, Vision, Prescription Drug, Employee Assistance Program, and Health Care Spending Account), initial claims for benefits under the Plan should be made by you in writing to the Claims Administrator.

Types of Claims

There are several different types of claims that you may bring under the Plan. The Plan's procedures for evaluating claims (for example, the time limits for responding to claims and appeals) depend upon the particular type of claim. The types of claims that you generally may bring under the Plan are as follows:

- Pre-Service Claim - A "pre-service claim" is a claim for a particular benefit under the Plan that is conditioned upon you receiving prior approval in advance of receiving the benefit. A pre-service claim must contain, at a minimum, the name of the individual for whom benefits are being claimed, a specific medical

condition or symptom, and a specific treatment, service or product for which approval is being requested.

- Post-Service Claim - A "post-service claim" is a claim for payment for a particular benefit or for a particular service after the benefit or service has been provided. A post-service claim must contain the information requested on a claim form provided by the applicable provider. *Note: Claims under the Health Care Spending Account are always post-service claims.*
- Urgent Care Claim - An "urgent care claim" is a claim for benefits or services involving a sudden and urgent need for such benefits or services. A claim will be considered to involve urgent care if the Claims Administrator or a doctor with knowledge of your condition determines that the application of the claims review procedures for non-urgent claims (i) could seriously jeopardize your life or your health, or your ability to regain maximum function, or (ii) in your doctor's opinion, would subject you to severe pain that cannot adequately be managed without the care or treatment that is the subject of the claim.
- Concurrent Care Review Claim - A "concurrent care review claim" is a claim relating to the continuation/reduction of an ongoing course of treatment.

Time Periods for Responding to Initial Claims

If you bring a claim for benefits under the Plan, the Claims Administrator will respond to your claim within the following time periods:

- Post-Service Claim - In the case of a post-service claim, the Claims Administrator shall respond to you within 30 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 30-day period that the Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is necessary because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.
- Pre-Service Claim - In the case of a pre-service claim, the Claims Administrator shall respond to you within 15 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 15-day period that the Claims Administrator needs up to an

additional 15 days to review your claim. If such an extension is because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.

- Urgent Care Claim - In the case of an urgent care claim, the Claims Administrator shall respond to you within 72 hours after receipt of the claim. If the Claims Administrator determines that it needs additional information to review your claim, the Claims Administrator will notify you within 24 hours after receipt of the claim and provide you with a description of the additional information that it needs to evaluate your claim. You will have no less than 48 hours from the time you receive this notice to provide the requested information. Once you provide the requested information, the Claims Administrator will evaluate your claim within 48 hours after the earlier of the Claims Administrator's receipt of the requested information, or the end of the extension period given to you to provide the requested information. There is a special time period for responding to a request to extend an ongoing course of treatment if the request is an urgent care claim. For these types of claims, the Claims Administrator must respond to you within 24 hours after receipt of the claim by the Plan (provided, that you make the claim at least 24 hours prior to the expiration of the ongoing course of treatment).
- Concurrent Care Review Claim - If the Plan has already approved an ongoing course of treatment for you and contemplates reducing or terminating the treatment, the Claims Administrator will notify you sufficiently in advance of the reduction or termination of treatment to allow you to appeal the Claims Administrator's decision and obtain a determination on review before the treatment is reduced or terminated.

Notice and Information Contained in Notice Denying Initial Claim

If the Claims Administrator denies your claim (in whole or in part), the Claims Administrator will provide you with written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally). This notice will include the following:

- Reason for the denial - the specific reason or reasons for the denial;
- Reference to Plan provisions - reference to the specific Plan provisions on which the denial is based;
- Description of additional material - a description of any additional material or information necessary for you to perfect your claim and an explanation as to why such information is necessary;

- Description of any internal rules - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
- Description of claims appeals procedures - a description of the Plan's appeals procedures and the time limits applicable for such procedures (such description will include a statement that you are eligible to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal and a description of any expedited review process for urgent care claims).

Appealing a Denied Claim for Benefits

If the Claims Administrator denies your initial claim for benefits, you may appeal the denial by filing a written request (or an oral request in the case of an urgent care claim) with the Appeals Administrator within 180 days after you receive the notice denying your initial claim for benefits. If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) to the Appeals Administrator for review and consideration. You will also be entitled to receive, upon request and free of charge, access to, and copies of, all documents, records, and other information that is relevant to your appeal.

Time Periods for Responding to Appealed Claims

If you appeal a denied claim for benefits, the Appeals Administrator will respond to your claim within the following time periods:

- Post-Service Claim - In the case of an appeal of a denied post-service claim, the Appeals Administrator shall respond to you within 60 days after receipt of the appeal.
- Pre-Service Claim - In the case of an appeal of a denied pre-service claim, the Appeals Administrator shall respond to you within 30 days after receipt of the appeal.
- Urgent Care Claim - In the case of an appeal of a denied urgent care claim, the Appeals Administrator shall respond to you within 72 hours after receipt of the appeal.
- Concurrent Care Review Claim - In the case of an appeal of a denied concurrent care review claim, the Appeals Administrator shall respond to you before the concurrent or ongoing treatment in question is reduced or terminated.

Notice and Information Contained in Notice Denying Appeal

If the Appeals Administrator denies your claim (in whole or in part), the Appeals Administrator will provide you with written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally or via facsimile or other similarly expeditious means of communication). This notice will include the following:

- Reason for the denial - the specific reason or reasons for the denial;
- Reference to Plan provisions - reference to the specific Plan provisions on which the denial is based;
- Statement of entitlement to documents - a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your claim and/or appeal for benefits;
- Description of any internal rules - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the appeal determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
- Statement of right to bring action - a statement that you are entitled to bring a civil action in Federal court under Section 502 of ERISA to pursue your claim for benefits.

If the time limitations set forth have not been exceeded, no person may bring an action in a court of law unless the claims review procedure is exhausted and a final determination has been made. The decision of the Appeals Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If you challenge the decision of the Appeals Administrator, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before you can pursue the claim in federal court. Facts and evidence that become known to you after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

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:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ERISA Claim Fiduciary

For the purposes of ERISA, all third party administrators and insurance carriers are fiduciaries, with complete authority to review all denied claims for benefits under this program. This includes, but is not limited to, the denial of certification of the medical necessity of hospital or medical treatment.

In exercising its fiduciary responsibility, the American Water Retirement / Benefits 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 the Plan. American Water Retirement / Benefits committee shall be deemed to have properly exercised such authority unless it acts arbitrarily or capriciously.

Plan Benefits

These benefits are provided by American Water. The following plans are self-insured benefits that are paid for directly by American Water:

- Standard Preferred Provider Organization (PPO) Plan
- Premium Preferred Provider Organization (PPO) Plan
- Exclusive Provider Organization (EPO) Plan
- Dental Plans
- Vision Plan
- Prescription Drug Program
- Short-Term Disability Plan
- Long-Term Disability Plan
- Health Care Spending Account
- Dependent Care Spending Account

Horizon provides certain administrative services for the Preferred Provider Organization and Flexible Spending Account Plans. Caremark administers the Prescription Drug Program. Aetna provides certain administrative services for the Dental Plans, Short-Term Disability, and Long-Term Disability Plans.

American Water, Horizon, Caremark, Aetna and EyeMed reserve the right to interpret all Plan provisions as necessary and to make all determinations regarding benefits payable under these American Water Employee Benefit Plans.

The following plan is fully insured:

- Life Insurance Plan

Plan Documents

In preparing this Summary Plan Description, American Water 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 Group Insurance Plan, the actual legal Plan documents and not this Summary Plan Description, will govern.

Continuation of Health Coverage

Introduction

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. For more information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

The Plan Administrator is Senior Vice President Human Resources, American Water, 1025 Laurel Oak Road, Voorhees, NJ 08043, (856) 346-8200. The Plan Administrator is responsible for administering COBRA continuation coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator in writing within 60 days after the qualifying event occurs. You must send this notice to the Benefits Service Center, American Water, 131 Woodcrest Road, Cherry Hill, NJ 08003, along with documentation of the event.

How Long Does COBRA Coverage Last?

COBRA continuation coverage is a temporary extension of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his or her employment terminates, COBRA continuation coverage for the spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage. If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide the Plan Administrator with notice of the Social Security Administration's determination within 60 days of the latest of (1) the date of the SSA's disability determination; (2) the date of the qualifying event; (3) the date on which the qualified beneficiary would lose coverage under the Plan; or (4) the date you are provided notice of

your COBRA continuation coverage rights. Notice should be sent to the Benefits Service Center, American Water, 131 Woodcrest Road, Cherry Hill, NJ 08003, along with a copy of the determination received from the Social Security Administration.

Second qualifying event extension of 18-month period of continuation coverage. If your spouse or dependent children experience another qualifying event while receiving 18 or 29 months of COBRA continuation coverage, the spouse and dependent children can get up to 36 total months of COBRA continuation coverage, if written notice of the second qualifying event is properly given to the Plan Administrator. This extension is available if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. If the second qualifying event is divorce or legal separation or the dependent child ceasing to be eligible under the Plan, written notice must be sent to the Benefits Service Center, American Water, 1025 Laurel Oak Road, Voorhees, NJ 08043, along with documentation of the second qualifying event.

How Do You Elect COBRA Coverage?

To elect continuation coverage, you must complete an election form supplied by the Plan Administrator within 60 days of the date you receive notice of your COBRA continuation coverage rights. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee’s spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

How Much Does COBRA Coverage Cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of continuation coverage due to a disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

Special Rules for the Health Care Spending Account

COBRA coverage will consist of the Health Care Spending Account coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the Plan Year, and COBRA coverage will terminate at the end of the Plan Year. Under the special grace period rule described on page 123, if you make all required COBRA premium payments through December 31, expenses incurred for the period January 1 – March 15 of the following calendar year can be applied against any remaining balance in your Health Care Spending Account. Expenses must be submitted by April 30 of the year following the year in which COBRA coverage commenced.

Unless otherwise elected, all qualified beneficiaries who were covered under the Health Care Spending Account will be covered together for Health Care Spending Account COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health Care Spending Account annual limit and a separate premium.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Benefits Service Center, 131 Woodcrest Road, Cherry Hill, NJ 08003, (866) 888-8269, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Conversion

If any coverage (other than Health Care Spending Account coverage) being continued under COBRA terminates because the end of the maximum continuation period has been reached, any Conversion Privilege will be available at the end of that period on the same terms as upon termination of employment or ceasing to be in an Eligible Class.

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 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 the appropriate carriers and American Water.

If American Water grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue any coverage you and your eligible dependents have under the American Water Plan at the time the leave commences.

Non-FMLA leaves, and benefits during such leaves, will be administered in accordance with specific leave policies established by American Water.

At the time you request the leave, you must agree to make any contributions required by American Water to continue coverage. At the time your leave begins, you will be advised on how to make payments. American Water will continue to make its contributions toward such coverage.

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.

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.

Maximum Length of Coverage

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 determines your approved FMLA leave is terminated;
- The date the coverage involved discontinues as to your Eligible Class.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

When FMLA Leave Terminates

If health care coverage terminates because your approved FMLA leave is deemed terminated by American Water, 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 You Return to Work

If you return to work for American Water following the date American Water 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 determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, you will not have a chance to re-enroll before the next Open Enrollment period.

Confidentiality of Protected Health Information

Title II of the Health Insurance Portability and Accountability Act of 1996 and the privacy regulations issued thereunder (collectively called "HIPAA") requires group health plans to protect the confidentiality of your private health information. This Plan will not use or disclose information that is protected by HIPAA ("Protected Health Information") except as necessary for treatment, payment, health care operations, and plan administration functions, or as otherwise permitted or required by law, without your written authorization. According to the law, the Plan has required all of its Business Associates to comply with the HIPAA privacy rules.

Before this Plan may disclose, or permit one of its agents or contractors to disclose, Protected Health Information ("PHI") to the Company, the Plan will require the Company to:

- certify that the information is necessary in connection with plan administration functions or other permitted functions performed or to be performed by the Company;
- amend the Plan documents and provide certification of amendment to give assurances that the Company will use and disclose the

information solely in connection with such plan administration or other permitted functions; and

- not use or further disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Company without your authorization.

Under HIPAA, you have certain rights with respect to your PHI, including the right to see and copy the information, to receive an accounting of certain disclosures of the information and, under certain circumstances, to amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services if you believe your rights under HIPAA have been violated.

List of Contacts

American Water Benefit Contacts		
Carrier	**Claims Administrator**	**Phone**
Medical		
Horizon	Horizon Blue Cross Blue Shield of New Jersey PO Box 820 Newark, NJ 07101 *www.horizonblue.com/nationalaccounts*	(800) 355-BLUE (2583)
Dental		
Aetna	Aetna * 1425 Union Meeting Rd. Blue Bell, PA 19422 *www.aetna.com*	(800) 292-4366
Vision		
EyeMed	Before enrollment: *www.eyemedvisioncare.com* After enrollment: *www.enrollwitheyemed.com/access*	(866) 939-3633
Flexible Spending Accounts		
Horizon	Horizon Healthcare 3 Penn Plaza East PP-05S Newark, NJ 07105-2200 *www.horizon-healthcare.com/fsa*	(800) 224-4426
Life and AD&D		
MetLife	MetLife One Madison Avenue New York, NY 10010 *www.metlife.com*	(800) 638-5433
	For information on Social Security benefits: *www.ssa.gov/pubs/deathbenefits.com or (800) 772-1213*	
Disability		
Aetna Managed Disability	Aetna * 1425 Union Meeting Rd. Blue Bell, PA 19422 *www.aetna.com*	(800) 804-5329
Employee Assistance Program		
Carebridge	Carebridge Corporation 40 Lloyd Avenue Malvern, PA 19355 *www.carebridge.com*	(800) 437-0911 (610) 993-0955
Benefits Service Center		
131 Woodcrest Road, Cherry Hill, NJ 08003 (866) 888-8269		

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 room and board and other necessary services and supplies. They must be made regularly at a daily or weekly rate.

Skilled Nursing/Convalescent Facility

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 RN, or by an LPN directed by a full-time RN, 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 RN.
- Is supervised full-time by a doctor or RN.
- 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

A fee charged to a person for Covered Medical Expenses, as specified in the applicable Summary of Coverage.

Course of Treatment

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, and

- Of definite duration.

Custodial Care

Services and supplies furnished to a person mainly to help him or her in the activities of daily life, including room and board and other institutional care. The person does not have to be disabled. These 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

A legally qualified dentist, or a doctor who is licensed to do the dental work he or she performs.

Directory

A listing of Network Providers in the Service Area covered under this Plan that is available to all employees covered under the Medical Plans.

Doctor

A legally qualified, licensed doctor.

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

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 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

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 doctor and one RN),
- Has full-time supervision by a doctor or RN,
- Keeps complete medical records on each person,
- Has a full-time administrator, and
- Meets licensing standards.

Home Health Care Plan

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 doctor, and
- An alternative to confinement in a hospital or skilled nursing/convalescent facility.

Hospice Care

Care given to a terminally ill person by or under arrangements with a Hospice Care Agency as part of a Hospice Care Program.

Hospice Care Agency

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 include:
  - services of a doctor,
  - 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 doctor,
  - one RN,

  - 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 doctors, 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 Facility

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 doctors other than those who own or direct the facility.
- Is run by a staff of doctors; at least one such doctor must be on call at all times.
- Provides 24-hour-a-day nursing services under the direction of an RN
- Has a full-time administrator.

Hospice Care Program

A written plan of Hospice Care, which:

- Is established by and reviewed from time to time by:
  - a doctor 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.

Hospital

A place that:

- Provides mainly inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of doctors.
- Provides 24-hour-a-day RN services.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home
- Makes charges for services rendered.

In-Network Care

A health care service or supply furnished by a Network Provider.

LPN

A licensed practical nurse.

Mental Disorder

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 disorders 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 Horizon 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, Horizon 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 Horizon'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 doctor's or a dentist's office or other less costly setting.

Negotiated Charge

The maximum charge a Network Provider has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

Network Provider

A health care provider that has contracted to furnish services or supplies for a Negotiated Charge, but only if the provider is, with Horizon's consent, included in the Directory as a Network Provider for:

- The service or supply involved, and
- The class of employees of which you are a member.

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.

Non-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.

Orthodontic Treatment

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.

Out-of-Network

A health care service or supply furnished by a health care provider that is not Network.

Out-of-Network Provider

A health care provider that has not contracted to furnish services or supplies at a Negotiated Charge.

Reasonable and Customary Charge

Only that part of a charge considered "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 Horizon 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, Horizon 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.

RN

A registered nurse.

Semi-Private Rate

The charge for room and board, which an institution applies to the most beds in its semi-private rooms with two or more beds. If there are no such rooms, Horizon will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Service Area

The geographic area in which Network Providers for this Plan are located, as determined by Horizon.

Terminally Ill

A medical prognosis of six months or less to live.

Totally Disabled

"Totally disabled" mean that because of injury or illness:

- You are unable to engage in your customary occupation and are not working for pay or profit.
- Your dependent is unable to engage in most of the normal activities of a person of like age and sex in good health.