American Water Group Insurance Plan Summary Plan Description For Union Employees In Effect as of January 1, 2006

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.

Table of Contents

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 in this booklet may vary depending on the terms of your union contract. Please refer to your union contract for details. 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 or terminate the benefit plans described in this summary at any time. Some of the employees

who participate in this Plan do so under the terms of collective bargaining agreements. The Company takes its obligations under those agreements very seriously and will, as required either by the Company's contractual agreements or by law, negotiate changes to the Plan affecting union members with those unions whose members participate in the Plan.

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

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

  (STD)
- Life Insurance

  (Basic, AD&D, Supplemental, Spouse and Dependent)
- 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 union 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) 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, (4) 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, or (5) an employee of the Electrical Workers Union, Local 51, Sterling, Illinois. If a leased employee or independent contractor 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 depends upon the terms of your union contract. 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/vision) 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.

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.

Exclusive Provider Organization (EPO)

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 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.

* This Opt Out of Coverage provision may vary or may not apply depending on the terms of your Union Contract.

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 a 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** will be in accordance with the terms of your union contract.

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. 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 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 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	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 months 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 Condition exclusions 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 pre-certification 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 Care

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

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 pre-certified 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

Pre-certification 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

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

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:

- 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 Condition exclusions 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.

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.

Other Covered Medical Expenses

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 Care

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 Medical Plans

Provisions That Apply to All Medical Plans

This section describes General Exclusions that apply under all Medical 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 and 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, 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 copayment 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.