The Dental Plans

Dental Benefits

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

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

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

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

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

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

Dental Plan Summary Chart

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

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

Covered Dental Expenses

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

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

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

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

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

- 80% of Preventive (Type A) expenses after the deductible.
- 50% of Restorative and Major Services (Type B) expenses after the deductible.

- There is no coverage for Orthodontia (Type C) expenses.

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

- Necessary,
- Customarily used nationwide, and
- Deemed by the profession to be appropriate. They must meet broadly accepted national standards of dental practice.

Type A Expenses – Preventive Services

- Oral exams once every six months. This includes prophylaxis, scaling, and cleaning of teeth.
- X-rays for diagnosis.
- Other X-rays (up to one full mouth series in a 36-month period and one set of bitewings in a 6-month period).

Type B Expenses – Restorative and Major Services

- Topical application of sodium or stannous fluoride for persons under 15 years of age.
- Space maintainers.
- Non-surgical extractions.
- Fillings.
- General anesthetics given in connection with covered dental services.
- Non-surgical treatment of diseased periodontal structures.
- Non-surgical endodontic treatment. This includes root canal therapy.
- Injection of antibiotic drugs.
- Repair or recementing of crowns, inlays, bridgework, or dentures.
- Relining of dentures.
- First installation of removable dentures to replace one or more natural teeth extracted while the person is covered. This includes adjustments for the 6-month period following the date they were installed.

- Replacement of an existing removable denture or fixed bridgework by a new denture, or the adding of teeth to a partial removable denture. Note: the "Prosthesis Replacement Rule" below must be met.
- Inlays, gold fillings, or crowns. This includes precision attachments for dentures.
- First installation of fixed bridgework to replace one or more natural teeth extracted while the person is covered. This includes inlays and crowns as abutments.
- Replacement of an existing removable denture or fixed bridgework by new fixed bridgework, or the adding of teeth to existing fixed bridgework. Note: the "Prosthesis Replacement Rule" below must be met.

Type C Expenses – Orthodontic Treatment (Premium PPO Dental Plan Only)

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

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

Advance Claim Review

You should request an Advance Claim Review of any dental program that will cost $150 or more. The review will tell you and your dentist what the Plan will cover and how much you must pay out of your own pocket.

Before starting a course of treatment for which the dentist's charges are expected to be $150 or more, details of the proposed course of treatment and charges to be made should be filed with Aetna. Please contact Aetna Member Services at (800) 292-4366 for additional details and to obtain forms. Aetna will then estimate the benefits and notify you and your dentist before treatment starts. Advance review is not required as a condition of receiving benefits, but it will let you

know what to expect as far as Plan benefits if you obtain more expensive treatment.

Some services may be given before an Advance Claim Review is made (emergency treatments and oral exams, including prophylaxis and X-rays).

A course of treatment is a planned program of one or more services or supplies to treat a dental condition. The condition must be diagnosed by the attending dentist as a result of an oral exam. The treatment may be given by one or more dentists. The course of treatment starts on the date a dentist first gives a service to correct or treat such dental condition.

Note: As a part of the Advance Claim Review and as part of proof of any claim, Aetna has the right to require an oral exam of the person at its own expense. You must give Aetna all diagnostic and evaluative material which it may require. These include: X-rays, models, charts, and written reports.

The benefits for a course of treatment may be less than you expect if an Advance Claim Review is not made or if any required verifying material is not furnished. Benefits will be reduced by the amount of expenses that Aetna cannot verify.

Alternate Treatment

If alternate services or supplies may be used to treat a dental condition, Covered Dental Expenses will be limited to those services and supplies which, as determined by Aetna:

- Are customarily used nationwide for treatment, and
- Are deemed by the profession to be appropriate for treatment. They must meet broadly accepted national standards of dental practice. The person's total current oral condition will be taken into account.
- The Limitations section has some examples of how this works. Please refer to page 103 for more information.

Prosthesis Replacement Rule

Certain replacements or additions to existing dentures or bridgework will be covered under this Plan. Aetna must receive satisfactory proof that:

- The replacement or addition of teeth is required to replace teeth extracted after the present denture or bridgework was installed. The person must have been covered when the tooth was extracted.
- The present denture or bridgework cannot be made serviceable, and it must be at least five years old.
- The present denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered and cannot be made permanent. Replacement by a permanent denture is needed and takes place within 12 months from the date the immediate temporary denture was first installed.

Explanation of Some Important Plan Provisions

Calendar Year Deductible

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

Family Deductible Limit

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

Coinsurance

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

Calendar Year Maximum Benefit

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

Coordination of Benefits

In many families, both husbands and wives work and may be eligible for benefits under more than one group medical or dental plan. In such situations, the various plans "coordinate" benefits to determine how covered expense will be paid by the American Water Plan and the other plans. This may mean a reduction in benefits under this Plan. The combined benefits will not be more than the expenses recognized under the American Water Plans.

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

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

For example, if you have Standard PPO Dental coverage and receive Preventive Care Services 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.

See "Coordination of Your Benefits with Other Plans, Not Including Medicare" on page 76 for the rules for determining primary and secondary plans.

Covered services and supplies must meet broadly accepted standards of dental practice. When your dentist uses an alternate method of treatment, the benefits paid by American Water Plan will be limited.

Limitations

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

Restorative and Reconstructive Services

- Gold, Baked Porcelain, Crowns, and Jackets

  Covered Dental Expenses will be limited to the charges for the procedure using amalgam or like material, if it would restore a tooth. This limit applies even if you and the dentist choose some other type of restoration.

- Reconstruction

  Covered Dental Expenses will be limited to the charges for the procedure needed to eliminate oral disease and replace missing teeth. Appliances or restorations needed to increase vertical dimension or restore the occlusion are deemed to be optional and are not covered.

Prosthodontic Services

- Partial Dentures

  Covered Dental Expenses will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. This limit applies even if you and the dentist choose a more elaborate or precision appliance.

- Complete Dentures

  Covered Dental Expenses will be limited to the charges for a standard procedure. This limit applies even if you and the dentist choose personalized or specialized treatment.

Replacement of Existing Dentures will be covered only if the existing denture cannot be used or repaired. If it can be used or repaired, Covered Dental Expenses will be limited to the charges for the services needed to make the denture usable.

When Coverage Is Terminated

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

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

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

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

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

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

You may be entitled to continue your dental coverage (see "Continuation of Health Coverage" on page 172).

Benefits After Termination of Coverage

If your dental coverage ends while you are not totally disabled, charges for dentures, fixed bridgework and crowns may be covered for a period of 60 days following the date coverage terminated if they were ordered before that date.

Expenses incurred for the following after the person's dental coverage ends because medical coverage ends will be deemed to be incurred when ordered:

- Dentures
- Fixed bridgework
- Crowns

This applies only if the item is finally installed or delivered no more than 60 days after coverage ends.

"Ordered" means:

- Impressions have been taken from which the dentures, crowns, or fixed bridgework will be made, and

For fixed bridgework and crowns, the teeth must have been fully prepared if they will serve as retainers or support or if they are being restored.

General Exclusions

Coverage is not provided for the following expenses:

- Services and supplies not necessary, as determined by Aetna, for the diagnosis, care, or treatment of disease or injury. This applies even if they are prescribed, recommended, or approved by the person's attending dentist.
- Care, treatment, services, or supplies that are not prescribed, recommended, and approved by the person's attending dentist.
- Treatment by someone other than a licensed dentist. (The Plan will cover some treatments by a licensed dental hygienist if supervised by a dentist, including scaling of teeth, cleaning of teeth, and topical application of fluoride.)
- Services or supplies determined by Aetna to be experimental or investigational. A drug, device, procedure, or treatment will be determined to be experimental or investigational if:
  - there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;
  - as required by the FDA, approval has not been granted for marketing;
  - a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or
  - the written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.
- Services of a resident doctor, dentist, or intern rendered in that capacity.
- Charges which Aetna determines not to be reasonable.
- Charges for services and supplies which are covered in whole or in part under any other part of this Plan, or under any other group benefits plan provided by American Water.
- Charges that are made only because there is health coverage.
- Charges that a covered person is not legally obliged to pay.
- Charges for services and supplies:

- furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government;
- furnished, paid for, or for which benefits are provided or required under any law of a government. (This does not include a plan established by a government for its own employees or their dependents or Medicaid.) An example is benefits provided, to the extent required by law, under "no-fault" auto insurance.

- Charges for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, including but not limited to charges for personalization or characterization of dentures, except to the extent needed to repair an injury which occurs while the person is covered under this Plan.
- Charges for routine dental exams or other preventive services and supplies.
- Charges for acupuncture therapy, unless performed by a doctor as a form of anesthesia in connection with surgery covered under the Plan.
- Charges for sealants.
- Charges for the replacement of a prosthetic device that is lost, missing, or stolen.
- Charges for services or supplies for orthodontic treatment, except as specifically provided.
- Charges for services or supplies to increase vertical dimension, such as dentures, crowns, inlays and onlays, bridgework, or any other appliance or service.

Any exclusion above will not apply to the extent that:

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

These excluded charges will not be used when calculating benefits.

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

Submitting Claims

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

All claims must be filed within two years from the date of the incurred expense. (See page 100 for information on filing Orthodontic Claims) Claims must be in writing and must include proof of the nature and extent of the expense. To obtain Dental Benefits Request forms, call Aetna Member Services at **(800) 292-4366** or visit their website at www.aetna.com.

How Your Benefits Are Paid

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

How to File a Dental Claim

Attach the original of each itemized bill to the Dentist's Statement form. Be sure to keep a copy of all bills and claim forms for your records.

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

- Complete all items under applicable sections of the claim form. Unanswered questions will cause delay in processing your claim.
- Be sure to include your Identification number on all claims, including claims for your dependent(s), and be sure to sign the form.
- Attach the itemized bill to the form. An itemized bill must contain the following information:
  - the patient's full name,
  - the patient's relationship to you,
  - the date service was provided,
  - the name of the Dentist or other licensed health care professional providing service,
  - the provider's taxpayer identification number,
  - the type of service provided,
  - the nature of the condition being treated, and
  - the charges for the service or treatment (multiple expenses should be itemized).

If any of this information is missing, write it on the bill yourself and sign your name. Your dental provider should complete the provider

section of the Benefits Request form if he or she has not given you an itemized statement.

If you have other group coverage that pays benefits before this Plan, you must provide Aetna with a copy of the other carrier's Explanation of Benefits (EOB) reflecting the benefits paid under the other coverage when you submit expenses for payment under this Plan.

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

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

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

No Assignment of Benefits

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

Your Contributions

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

The Vision Plan

Vision Benefits

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

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

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

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

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

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

Vision Benefits Summary Chart

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

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

Visiting an Out-of-Network Provider

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

Services Not Covered

The Vision Plan does not cover:

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

When Coverage Is Terminated

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

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

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

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

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

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

You may be entitled to continue your vision coverage (see "Continuation of Health Coverage" on page 172).

Filing a Claim

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

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

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

Claim forms and receipts should be mailed to:

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

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

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

No Assignment of Benefits

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

Your Contributions

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

Flexible Spending Accounts

Flexible Spending Accounts

Participation in the Health Care Spending Account and the Dependent Care Spending Account allows you to reduce your taxable income by paying for certain expenses with pre-tax dollars.

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

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

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

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

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

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

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

The Health Care Spending Account

You can use your Health Care Spending Account to pay for medical, dental, vision, and hearing care expenses that are not otherwise covered by any health care plan.

The Health Care Spending Account allows you to contribute money on a pre-tax basis to an account set up for you. If you (or your eligible dependents) incur qualifying health care expenses which are not covered, or are only partially covered, by insurance or any other source, you will be reimbursed from the spending account for these expenses.

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

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

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

Eligibility

To participate in the Health Care Spending Account, you must complete and submit an enrollment form within the 31-day enrollment period. If a signed form is not received within this period, American Water will assume that you have decided not to participate in the Plan, and you will not be eligible to participate until the following Plan Year.

If you are a regular full-time eligible employee (see "Eligibility" on page 3), you are eligible to participate in the Health Care Spending Accounts according to the terms of your union contract. You may enroll by completing and signing the appropriate Flexible Spending Account section on your Enrollment Form. If you are newly hired, ***you must enroll*** and make your contribution election within the 31-day enrollment period. You will have the opportunity to change your elections in the fall of every year, effective for the upcoming plan year. You are not permitted to make changes to your election amount during the Plan Year, except under certain circumstances (see page 122).

Eligible Dependents

Health Care expenses incurred by your eligible dependents can be reimbursed if the expenses are not covered by any medical, dental, vision or prescription drug plan.

In addition to your own expenses, you can also be reimbursed from the Health Care Spending Account for qualifying expenses incurred by an eligible dependent. For you to include these expenses, the person must have been your dependent either at the time the medical services were provided or at the time you paid the expenses.

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

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

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

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

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

A **qualifying relative** is your:

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

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

How the Account Works

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

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

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

Claim Documentation

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

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

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

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

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

How Much Can I Contribute?

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

You may elect to contribute up to $2,500 per year to your Health Care Spending Account

You may elect to contribute up to $2,500 per year (this may vary depending on the terms of your union contract) to the Health Care Spending Account. There is a minimum contribution of $120 per calendar year. If your spouse also has a health care spending account, whether through the Company or another employer, this will not affect the maximum amount of your contribution. You may each contribute the maximum amount.

The amount available to you for reimbursement for qualifying expenses incurred during the Plan Year (plus the 2½ month grace period) is the annual amount you have elected to contribute to the spending account, even if the full amount has not yet been deducted from your pay. For example, if you elect to contribute $1,200 to the spending account, the entire $1,200 will be available to you for reimbursement of your eligible expenses beginning January 1. *Note that there is a different rule for reimbursements from the Dependent Care Spending Account.*

Use All the Money In Your Account

According to IRS rules, any amounts remaining in your spending account after the deadline for submitting claims incurred during the Plan Year (plus the 2½ month grace period) will be forfeited. You may not carry forward unused amounts to the next Plan Year, and you may not transfer unused amounts from the Health Care Spending Account to another employee or to another plan or account (such as the Dependent Care Spending Account). Therefore, you should plan carefully before you make your annual contribution election. Any forfeited amounts are used by American Water to reduce future administrative expenses.

You must request reimbursement by April 30 of the following year for health care expenses incurred during the Plan Year and the grace period (the following January 1 – March 15).

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

Can I Change the Amount of My Contributions?

You can start, stop, or change the automatic deductions from your paycheck during the calendar year only if you have a change in status (as listed below). The change in status must be on account of, and correspond with, a change in status affecting eligibility. The following events are changes in status:

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

Expenses Eligible for Reimbursement

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

- Medical, dental, and vision care expenses incurred by you or an eligible dependent in the diagnosis, treatment, or prevention of disease, including prescription drug expenses and transportation or lodging expenses incurred in receiving treatment.
- Certain other medical expenses not covered by your medical insurance.
- Deductibles or copayments you have paid under any type of health care plan.
- Over-the-counter medicines and drugs purchased without a prescription, provided they are for the diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body. The over-the-counter drug must be more than just beneficial to general health and not "cosmetic" in nature.

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

Remember the following lists of eligible and ineligible expenses are not complete. If you have a question as to whether or not an expense is eligible, please call Horizon FSA at (800) 224-4426.

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

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

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

- Acupuncture (excluding remedies)
- Adoption
- Adult diapers
- Alcoholism treatment
- Ambulance
- Artificial insemination

- Artificial limbs/teeth
- Birth control
- Braille books/magazines
- Chiropractic treatment
- Christian Science practitioners
- Coinsurance/deductibles
- Contact lenses/saline solution
- Copayments
- Cosmetic Surgery:
  - to treat illness/disease
  - to improve a congenital abnormality
  - to treat injury from accident/trauma
  - to improve a disfiguring deformity
- Crutches
- Deductibles
- Dental treatment and oral surgery (non-cosmetic only)
- Dentures
- Diagnostic fees
- Dietary supplements and vitamins with doctor's letter of medical necessity
- Doctor fees (cosmetic procedures not eligible)
- Drug addiction treatments
- Drug and medical supplies (i.e. syringes, needles, etc.)
- Excess of reasonable and customary charges scheduled, annual, or lifetime maximums
- Eye care/exams
- Eye surgery (cataracts, LASIK, etc.)
- Eyeglasses (prescription only)
- Guide dogs
- Hearing aids/exams
- Hearing devices and batteries
- Home health care
- Hospital bills
- Insulin
- In-vitro fertilization
- Laboratory fees
- Nursing home costs
- Orthodontia (non-cosmetic only)
- Orthopedic devices

- Over-the-counter drugs that are medically necessary like allergy medications, aspirin, or antacids (see list below)
- Oxygen
- Prescribed medicines
- Psychiatric treatment
- Psychologist's fees
- Routine physicals and other non-diagnostic services or treatments
- Smoking-cessation over-the-counter drugs
- Smoking cessation programs
- Specialized car equipment for disabled persons
- Speech therapy
- Sterilization
- Surgical fees
- Transplants (except hair)
- Vaccinations and immunizations
- Vitamins, with doctor's letter of medical necessity
- Weight loss programs
- Weight-loss over-the-counter drugs with doctor's letter of medical necessity
- Well-baby care
- Wheelchairs
- X-ray fees

Over-The-Counter Items

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

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

Dual Use Items

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

- Adhesive or elastic bandages
- Blood pressure meter

- Cold or hot compresses
- Eye drops
- Foot spa
- Gauze and tape
- Gloves and masks
- Herbs
- Leg or arm braces
- Massagers
- Minerals
- Multivitamins
- Saline nose drops
- Special supplements
- Special teeth cleaning system
- Thermometers

Expenses Not Eligible for Reimbursement

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

- Bleaching/bonding of teeth
- Contact lens insurance
- Cosmetic surgery, unless necessary to correct a deformity which is congenital or which resulted from a disfiguring illness or an injury resulting from an accident or trauma
- Dancing lessons
- Diaper services for children
- Electrolysis
- Expenses for general health purposes, such as fitness, exercise, or health club dues unless recommended by a doctor for a particular medical condition
- Expenses for weight loss programs *unless* recommended by a doctor to treat obesity
- Expenses in excess of the amount you have elected to contribute to the Health Care Spending Account
- Expenses of someone who is not an eligible dependent
- Funeral expenses
- Hair restoration (procedures, drugs, or medications)
- Hair transplants
- Health club or gym memberships for general health
- Household help
- Insurance premiums (including COBRA premiums)
- Liposuction

- Marriage and family counseling
- Maternity clothes
- Over-the-counter items, drugs, or medications that are not medically necessary or are not prescribed by your doctor
- Premiums you or your spouse pay for insurance coverage
- Rogaine, when used for cosmetic purposes; that is, to stimulate growth, and not for a specific medical condition
- School tuition
- Swimming lessons
- Transportation costs of a disabled person to and from work
- Vacation or travel costs to improve health
- YMCA/YWCA memberships

This list is intended to give you a general description of expenses not eligible for reimbursement through the spending account. *There may be other expenses, in addition to those listed above, which are not eligible.*

Over-the-Counter Expenses Not Eligible for Reimbursement

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

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

- Sun tanning products
- Toothbrushes

Submitting Claims

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

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

- The name of the patient and the employee,
- The date(s) the services were provided,
- A description of the service or item provided,
- The name and address of the provider,
- The cost of the service or item.

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

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

You will receive an Explanation of Payment (EOP) statement from Horizon detailing the status of your account with each reimbursement.

Family and Medical Leaves of Absence

If you take a Family and Medical Leave of Absence (FMLA Leave) from American Water, your pre-tax payroll deductions to the Health Care Spending Account will stop. You may continue to make contributions on an after-tax basis only by sending a monthly check to American Water.

Termination/ Retirement of Employment

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

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

The Dependent Care Spending Account

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

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

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

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

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

Eligibility

If you are a regular full-time eligible employee (see "Eligibility" on page 3), you are eligible to participate in the Dependent Care Spending Account in accordance with the terms of your Union contract. You may enroll by completing and signing the appropriate Flexible Spending Account section on your Enrollment Form. If you are newly hired, **you must enroll** and make your contribution election within the 31-day enrollment period. You will have the opportunity to change your elections in the fall of every year, effective for the upcoming plan year. You are not permitted to make changes to your election amount during the Plan Year, except under certain circumstances (see page 134).

Qualifying Dependents

Expenses are reimbursable for care of the following qualifying dependents:

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

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

How the Account Works

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

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

How Much Can I Contribute?

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

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

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

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

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

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

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

In addition, your Dependent Care Spending Account contribution can never be more than your earned wages or your spouse's earned wages, whichever is less. If your spouse is a full-time student, the IRS considers him or her to be gainfully employed, with earned income of $250 per month (if you have one qualifying dependent) or $500 per month (if you have two or more qualifying dependents) for each month the spouse is a student. To be considered a "full-time student" as defined by the IRS, your spouse must maintain full-time status at a college or university during at least five months of the year.

Determining How Much to Contribute

The amount you elect to contribute will depend upon the amount you anticipate you will need to cover your dependent care expenses for the Plan Year (January 1 -- December 31). You should compare the tax benefit you would receive with the Dependent Care Spending Account

to the benefit that you would receive with the Federal child and dependent care tax credit (see below), and then choose between them. For additional details about the Federal tax credit, see IRS Publication 503 ("Child and Dependent Care Expenses") and IRS Tax Topic 602 (www.irs.gov/taxtopics/tc602.html). You can request a copy of Publication 503 from your local IRS office or go online at www.irs.gov/publications/p503.

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

Use All the Money in Your Account

You must request reimbursement by March 31 of the following year for dependent care expenses incurred on or before December 31 of each Plan Year.

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

Expenses Eligible for Reimbursement

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

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

You may receive reimbursement from your account for expenses that have been incurred for services rendered during the Plan Year. In order to be reimbursed for these expenses, the tax ID number or Social Security number of the provider must be submitted.

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

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

Expenses Not Eligible for Reimbursement

Expenses ineligible for reimbursement include the following:

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

This list is intended to give you a general description of expenses not eligible for reimbursement through the spending account. There may be other expenses in addition to those listed above which are not eligible.

Can I Change the Amount of My Contributions?

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

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

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

Submitting Claims

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

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

- The dependent's name and age,
- The nature of the care provided,
- The date(s) the care was provided,
- The amount paid for the care,
- The dependent's relationship to you, and
- The name and taxpayer identification number (or Social Security number) of the care provider.

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

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

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

You will receive an Explanation of Payment (EOP) statement from Horizon detailing the status of your account with each reimbursement.

Family and Medical Leaves of Absence

If you take a Family and Medical Leave of Absence (FMLA Leave) from American Water, your pre-tax payroll deductions to the Dependent Care Spending Account will stop. You may submit claims for reimbursement for care provided through your last day of work before your leave began.

Termination of Employment

If you terminate or retire from American Water, your pre-tax payroll deductions to the Dependent Care Spending Account will stop. You may still continue to submit claims for reimbursement of expenses incurred **before** your date of termination. Expenses for care provided after your date of termination are not eligible for reimbursement. COBRA continuation coverage does not apply to the Dependent Care Spending Account.

Short Term Disability Coverage (STD)

Disability Benefits

Disability benefits provide income protection when you are unable to work because of an extended illness or injury. American Water provides you with Short-Term Disability (STD) benefits at no cost to you.

You are eligible for STD benefits if you are a full-time eligible employee (refer to your union contract to see if you are eligible for this benefit). Part time employees and temporary employees are not eligible, unless specified by state laws.

Your eligibility date is in accordance with the terms of your union contract. If you are on a layoff, on disability, or on leave of absence on your eligibility date, coverage or an increase in coverage will begin on the day you return to active full-time work for one full day.

After a waiting period, this plan will pay an STD benefit of $300 for each week of a disability absence (unless superseded by State law), increasing by $10 per year on January 1st of each future year as follows:

2006 - $300

2007 - $310

2008 - $320

2009 - $330

2010 - $340

The amounts listed above may vary according to the terms of your union contract.

The absence must start while you are covered under the Plan. A disability absence is lost time from work because of a non-occupational injury or illness which stated while you were covered under this plan

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

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

for any period of time in which you are eligible to receive paid sick leave, and the combination of paid sick leave and STD benefits will not exceed 52 weeks. The number of weeks eligible for STD may vary according to the terms of your union contract.

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

More than one disability absence will be part of the same period of disability:

- If it is due to the same or a related cause, and
- If it is separated by less than 2 consecutive weeks of full-time work.

Your Maximum Period of Payment starts over if:

- A new disability absence is due to a cause different from that of any prior disability, and
- It is separated from the prior disability by at least one day of full-time active work.

STD Benefit Limitations

No benefits are payable for:

- Days on which you do work for pay or profit outside American Water.
- Any period of time you are not under a doctor's care. You must have been seen in person and treated by a doctor to be deemed under his or her care.

Coverage for Occupational Illness or Injury

This Plan pays a weekly benefit if you are absent from work, while covered, because of an illness or injury resulting from employment with American Water. However, the Weekly Benefit amount will be reduced by the weekly amount for which you are eligible for time lost under any Workers' Compensation law or any other similar law or doctrine. This benefit runs concurrently with sick leave.

Submitting STD Claims

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

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

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

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

Third Party Liability and Subrogation

General Principle

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

Specific Requirements and Plan Rights

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

worded, and even if you have not been paid or fully reimbursed for all damages or expenses.

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

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

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

Participant Duties and Actions

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

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

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

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

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.

Life Insurance

Life Insurance Benefits

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

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

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

Please note: Benefit amounts may vary depending on the terms of your union contract.

Basic	1.25 times your base pay (maximum benefit $200,000)
Accidental Death and Dismemberment	Up to maximum benefit of $10,000
Voluntary	1, 2, or 3 times your base pay (maximum benefit $1,000,000)
Voluntary Dependent	$20,000 (spouse) and $10,000 per dependent child

Eligibility

If you are a full-time eligible employee (see "Eligibility" on page 3), you are eligible to participate in American Water Life Insurance Benefit Plans. Your eligibility and participation date is in accordance with your union contract provided you are then actively working or would have been able to work had you been scheduled to work that day. If you are on a layoff, on disability, or on leave of absence on your eligibility date, coverage or an increase in coverage will begin on the day you return to active work.

Basic Life Insurance *

Your Company-paid life insurance amount is equal to 1.25 times your base pay, rounded to the next higher $1,000. The maximum benefit is $200,000.

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

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

* Benefit amount may vary depending on the terms of your union contract.

Imputed Income

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

Accelerated Death Benefits

If you (or your spouse, if enrolled in voluntary dependent coverage) become terminally ill while covered under the Life Insurance program, you may request that MetLife pay an Accelerated Death Benefit.

"Terminally ill" is defined as a person who:

- suffers from an incurable, progressive, and medically recognized disease or condition; and
- to a reasonable medical probability and based on generally accepted protocols, will not survive longer than six (6) months.

You may request an Accelerated Death Benefit on your own behalf or on behalf of your spouse (if enrolled in voluntary dependent coverage) at any time by completing a MetLife Request for Accelerated Death Benefit Form and submitting it to MetLife. The request must include the statement of a currently licensed United States doctor that you or your spouse is terminally ill.

The doctor's statement must include:

- all medical test results,

- laboratory reports, and
- any other information on which the statement is based, including the generally accepted protocols used by the doctor to determine the person's expected remaining life span.

Your request for an Accelerated Death Benefit must state the amount of the benefit requested. The Plan includes an Accelerated Death Benefit of 50% of your normal death benefit to you or your spouse in the event of a terminal illness. The Accelerated Death Benefit Minimum is $5,000 and the Accelerated Death Benefit Maximum is $100,000 of Basic Life Insurance and $300,000 of Voluntary Life Insurance.

This benefit can be requested only once on your own behalf and once for your spouse. If someone other than you owns the Life Insurance coverage for you and your spouse, the Accelerated Death Benefit will not be available under this Plan for or on behalf of such person.

Age Reduction Rule

Your Life Insurance amount in force on the day before the month of your 70th birthday will be reduced by 35% at age 70; 60% at age 75; and 75% at age 80.

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

Life Insurance After Termination

In most cases, you may apply for an individual policy under the Conversion Privilege within 31 days after your American Water Life Insurance ceases. If you die during this 31-day period and before the individual policy goes into effect, the amount payable under the group policy is limited to the maximum that could have been converted. The limit applies even if you have not applied for, or paid the first premium on, the individual policy. This applies to Basic and Voluntary life insurance.

Conversion of Your Life Insurance

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

Your converted policy may be any kind of individual policy then customarily being issued by MetLife for the amount being converted and for your age (nearest birthday) on the date it will be issued, except a term policy or one with disability or other supplementary benefits.

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

Applying for an Individual Policy

In order to convert, you must make written application for an individual policy and pay the first premium within 31 days after insurance ends for any of the above reasons. No evidence of insurability (that is, proof of good health) will be required. The individual policy will become effective at the end of the 31-day period during which conversion is possible.

The premiums for the converted policy will be at MetLife's then customary rates for the same policy issued to any other person of the same class of risk and age at the time the converted policy is to become effective.

After an individual policy becomes effective for any person, that policy will be in exchange for all benefits and privileges under the group contract as regards the person involved and the amount that could have been converted.

In most cases, you may apply for an individual policy under the Conversion Privilege within 31 days after your American Water life insurance ceases. If you die during this 31-day period and before the individual policy goes into effect, the amount payable under the group policy is limited to the maximum that could have been converted. The limit applies even if you have not applied for, or paid the first premium on, the individual policy.

Effect of Prior Coverage

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

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

A person's life insurance under this Plan replaces and supersedes any prior life insurance. It will be in exchange for everything under the prior life insurance. If you or your beneficiary become entitled to a claim under the prior life insurance, your Life Insurance under this Plan will be canceled as of its effective date and any premiums paid

for your life insurance under this Plan will be returned to American Water

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

Voluntary Life Insurance

Voluntary Coverage for You

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

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

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

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

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

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

Voluntary Coverage for Your Dependents

You can also buy supplemental life insurance coverage of $20,000 for your spouse and $10,000 for each dependent. Eligible dependents include children age 14 days to age 19, or to age 23 if a full-time student.

Cost

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

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

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

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

Optional Employee Group Term Life Insurance

Participation Frozen as of December 31, 1995

Participation in the current Optional Employee Group Term Life Insurance program was frozen as of December 31, 1995. If you are currently enrolled in either of the two options of this plan, your participation will continue while you remain actively employed. Participants' life insurance amounts will increase as their salary increases, according to the following plan options:

Option A

100% of your Salary Scheduled Amount, up to $40,000 of coverage.

Option B

50% of your Salary Scheduled Amount, up to $20,000 of coverage.

Employees enrolled in this plan have coverage as indicated in the following chart.

The Plans will pay a life insurance benefit equal to the amount of life insurance in force for you if you die from any cause while insured. This benefit will end upon retirement or termination, but can be converted to an individual policy.

Annual Basic Earnings	Insurance	
	Option A (100%)	Option B (50%)
$38,000 or more	$40,000	$20,000
$35,000 but less than $38,000	$38,000	$19,000
$32,000 but less than $35,000	$35,000	$17,500
$29,000 but less than $32,000	$32,000	$16,000
$26,000 but less than $29,000	$29,000	$14,500
$22,500 but less than $26,000	$26,000	$13,000
$19,500 but less than $22,500	$23,000	$11,500
$16,500 but less than $19,500	$20,000	$10,000
$13,500 but less than $16,500	$17,000	$8,500
$10,400 but less than $13,500	$14,000	$7,000
$7,280 but less than $10,400	$10,000	$5,000
$5,200 but less than $7,280	$7,000	$3,500
Less than $5,200	$5,000	$2,500

Beneficiaries

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

You may name or change your beneficiary by submitting a Beneficiary Designation Form, which is available from the Benefits Service

Center. The naming or any change will take effect on the date the Benefits Center receives your completed Beneficiary Designation Form.

Any amount payable to a beneficiary will be paid to those you name. Unless you state otherwise, if more than one beneficiary is named, they will share on equal terms.

If a named beneficiary dies before you, his or her share will be payable in equal shares to any other named beneficiaries who survive you.

If no named beneficiary survives you or if no beneficiary has been named, payment will be made as follows to those who survive you:

- Your spouse, if any.
- If you have no spouse, in equal shares to your children.
- If you have no spouse or child, to your parents, equally or to the survivor.
- If you have no spouse, child, or parent, in equal shares to your brothers and sisters.
- If none of the above survives, to your executors or administrators.

Permanent and Total Disability Benefits

For the purposes of a Permanent and Total Disability benefit, you are considered permanently and totally disabled only if:

- An illness or injury stops you from working at:
  - your own job, or
  - any other job for pay or profit,

  and it must continue to prevent you, for life, from working at any reasonable job. A "reasonable job" is any job for pay or profit, which you are, or may reasonably become, fitted for by education, training, or experience, or

  You lose one of these functions:
  - the sight of both eyes,
  - the use of both hands,
  - the use of both feet,
  - the use of one hand and one foot.

You must meet all of the following to be eligible for a Permanent and Total Disability benefit:

- Your Life Insurance must be in force when you become permanently and totally disabled.
- You must be under age 60 when you first become permanently and totally disabled.
- You must furnish all proof when requested. MetLife has the right to examine you, at its expense, before approving the proof.

Waiver

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

Any total disability should be reported immediately to American Water for help in determining whether you qualify for this extended insurance and the amount of insurance that may be continued. Refer to the Age Reduction Rule and Conversion Privilege, which may apply to this life insurance amount.

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

Extended Death Benefit

If MetLife receives proof, at its Home Office, that all of the following apply, it will pay your beneficiary, as a Permanent and Total Disability benefit, the amount of life insurance in force on your life when the total disability began:

- Premium payments for your life insurance stop while you are totally disabled by illness or injury, which stops you from working in any reasonable job.
- You die during the uninterrupted continuance of the total disability. Death occurs no later than 12 months after premium payments from American Water cease.
- You would have qualified for the Permanent and Total Disability benefit except that:

- your total disability did not last at least six months, or
- the required proof was not yet received or approved by MetLife.

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

When MetLife approves a claim for any benefit under this feature, the benefit will be in full settlement and satisfaction of MetLife's obligations.

If any individual policy has been issued to you under the Conversion Privilege, your rights under this section may be restored. In order to restore those rights, you must give up all such policies without claim, except for the return of the premiums you paid.

*Accidental Death and Dismemberment Coverage (AD&D)**

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

Your Company-paid AD&D Insurance pays up to a maximum of $10,000.00 (called the "Principal Sum"). The following must occur for benefits to become payable: while insured, you suffer a bodily injury in an accident and, within 90 days after the accident and as a direct result of the injury:

- You die.
- You lose a hand, at or above the wrist joint.
- You lose a foot, at or above the ankle joint.
- You suffer the irrecoverable and complete loss of sight in the eye.
- Your full Principal Sum is payable if you die. Half your Principal Sum is payable if you lose a hand, foot, or eye. No more than the Principal Sum is payable for all losses which result from one accident. Benefits are paid for losses caused by accidents only.

No benefits are payable for a loss caused or contributed to by:

- Bodily or mental infirmity.
- Disease, ptomaines, or bacterial infections.
- Medical or surgical treatment.

- Suicide or attempted suicide (sane or insane).
- Intentionally self-inflicted injury.
- War or any act of war (declared or undeclared).
- Participation in a riot or an attempt or commission of a felony.

These limitations do not apply if the loss is caused by:

- An infection, which results directly from the injury.
- Surgery needed because of the injury.

* Benefit amount may vary depending on the terms of your union contract.

Submitting Claims

For Survivor's Benefits

To receive survivor's benefits under Basic Life Insurance Plan, Optional Employee Group Term Life Plan, or Voluntary Life Insurance Plan, your beneficiary must complete and submit the appropriate Statement of Claim form and provide a certified death certificate to the Benefits Service Center within one year of the death.

If you were totally disabled at the time of your death and American Water was continuing your coverages at no cost to you, your beneficiary may be required to submit proof that total disability was continuous up to the date of your death.

For AD&D Benefits

To receive AD&D benefits, you must complete and submit the appropriate Statement of Claim form and provide proof documenting your loss to the Benefits Service Center within 30 days after the loss occurs. In some cases, you may be requested to undergo an independent medical examination before benefits can be paid.

How Benefits Are Paid

Approved survivors' and AD&D benefits are paid in a lump sum. However, other payment options may be available from MetLife. The Benefits Service Center will provide information about optional payment methods when you or your beneficiary are eligible to receive benefits.

Employee Assistance Program (EAP)

Employee Assistance Program

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

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

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

Additional Plan Information

Additional Plan Information

- **Plan Sponsor**

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

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

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

- **Plan Number** – 501

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

  January 1, 2006

- **Plan Year**

  January 1 through December 31st

- **Type of Plan**

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

- **Type of Administration**

  Self-Insured/Administrative Services Contract/Fully Insured

- **Plan Administrator**

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

- **Agent for Service of Legal Process**

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

- **Source of Contributions**

  Employer and Employee

- **Appeals Administrator**

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

- **Unions**

  A complete list of sponsoring unions may be obtained by participants upon written request and is available for examination upon request.

Plan Notices

Medicare Part D Notice

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

Medicare Part B Enrollment

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

Can I delay Medicare Part B enrollment without paying higher premiums?

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

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

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

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

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

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

Amendment or Termination of the Plan

The Right to Amend or Terminate the Plan

American Water reserves the right to amend all or any of our employee benefit plans at any time, including the right to change eligibility criteria or program costs and the right to restrict or eliminate benefits provided. The decision to change or end the plans may be caused by changes in federal or state laws governing benefits, the requirements of the Internal Revenue Code or ERISA, or any other reason.

The authority to make any such changes to the Plan generally rests with the Board of Directors of American Water or its designee, although the Plan Administrator may also change the Plan as required by law or in a manner which will not result in a material cost.

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.

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

Filing a Claim

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

Claim Determination and Appeals Process

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

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

A request for benefits is a "claim" subject to these procedures only if you or your authorized representative file it in accordance with the Plan's claim filing guidelines. In general, claims must be filed in

writing (except urgent care claims, which may be made orally) with the applicable provider. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim) must be filed with the Plan Administrator at the address set forth in the "Additional Information" section on page 158. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim. If a claim is received but there is not enough information to allow the Claims Administrator to process the claim, you will be given an opportunity to provide the missing information.

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

Claims Not Involving Health Benefits

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

Time Periods for Responding to Initial Claims

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

Notice and Information Contained in Notice Denying Initial Claim

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

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

Appealing a Denied Claim for Benefits

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

Time Periods for Responding to Appealed Claims

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

Notice and Information Contained in Notice Denying Appeal

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

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

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

Claims Involving Health Benefits

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

Types of Claims

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

particular type of claim. The types of claims that you generally may bring under the Plan are as follows:

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

Time Periods for Responding to Initial Claims

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

- Post-Service Claim - In the case of a post-service claim, the Claims Administrator shall respond to you within 30 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 30-day period that the Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is necessary because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator.

You will have no less than 45 days from the date you receive the notice to provide the requested information.

- Pre-Service Claim - In the case of a pre-service claim, the Claims Administrator shall respond to you within 15 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 15-day period that the Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.
- Urgent Care Claim - In the case of an urgent care claim, the Claims Administrator shall respond to you within 72 hours after receipt of the claim. If the Claims Administrator determines that it needs additional information to review your claim, the Claims Administrator will notify you within 24 hours after receipt of the claim and provide you with a description of the additional information that it needs to evaluate your claim. You will have no less than 48 hours from the time you receive this notice to provide the requested information. Once you provide the requested information, the Claims Administrator will evaluate your claim within 48 hours after the earlier of the Claims Administrator's receipt of the requested information, or the end of the extension period given to you to provide the requested information. There is a special time period for responding to a request to extend an ongoing course of treatment if the request is an urgent care claim. For these types of claims, the Claims Administrator must respond to you within 24 hours after receipt of the claim by the Plan (provided, that you make the claim at least 24 hours prior to the expiration of the ongoing course of treatment).
- Concurrent Care Review Claim - If the Plan has already approved an ongoing course of treatment for you and contemplates reducing or terminating the treatment, the Claims Administrator will notify you sufficiently in advance of the reduction or termination of treatment to allow you to appeal the Claims Administrator's decision and obtain a determination on review before the treatment is reduced or terminated.

Notice and Information Contained in Notice Denying Initial Claim

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

- Reason for the denial - the specific reason or reasons for the denial;
- Reference to Plan provisions - reference to the specific Plan provisions on which the denial is based;
- Description of additional material - a description of any additional material or information necessary for you to substantiate your claim and an explanation as to why such information is necessary;
- Description of any internal rules - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
- Description of claims appeals procedures - a description of the Plan's appeals procedures and the time limits applicable for such procedures (such description will include a statement that you are eligible to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal and a description of any expedited review process for urgent care claims).

Appealing a Denied Claim for Benefits

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

Time Periods for Responding to Appealed Claims

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

- Post-Service Claim - In the case of an appeal of a denied post-service claim, the Appeals Administrator shall respond to you within 60 days after receipt of the appeal.
- Pre-Service Claim - In the case of an appeal of a denied pre-service claim, the Appeals Administrator shall respond to you within 30 days after receipt of the appeal.

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

Notice and Information Contained in Notice Denying Appeal

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

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

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

established above. Issues not raised during the appeal will be deemed waived.

Your Rights Under ERISA

What Are Your Rights?

The intent of this book is to meet the Summary Plan Description requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA). However, if there is a conflict between the information contained in the official Plan documents and the information contained in this book, the information in the Plan documents will take precedence.

Under ERISA, you are entitled to:

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

Assistance with Your Questions

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

ERISA Claim Fiduciary

For the purposes of ERISA, all third party administrators and insurance carriers are fiduciaries, with complete authority to review all denied claims for benefits under this program. This includes, but is not limited to, the denial of certification of the medical necessity of hospital or medical treatment.

In exercising its fiduciary responsibility, the American Water Retirement / Benefits Committee shall have discretionary authority to determine whether and to what extent employees and beneficiaries are entitled to benefits, and to interpret any disputed or doubtful terms of the Plan. American Water Retirement / Benefits Committee shall be deemed to have properly exercised such authority unless it acts arbitrarily or capriciously.

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

Plan Benefits

These benefits are provided by American Water. The following plans are self-insured benefits that are paid for directly by American Water:

- Standard Preferred Provider Organization (PPO) Plan
- Premium Preferred Provider Organization (PPO) Plan
- Exclusive Provider Organization (EPO) Plan
- Dental Plans
- Vision Plan
- Prescription Drug Program
- Short-Term Disability Plan
- Health Care Spending Account
- Dependent Care Spending Account

Horizon provides certain administrative services for the Preferred Provider Organization, the Exclusive Provider Organization and the Flexible Spending Account Plans. Caremark administers the Prescription Drug Program. Aetna provides certain administrative services for the Dental Plans and Short-Term Disability Plans.

American Water, Horizon, Caremark, Aetna and EyeMed reserve the right to interpret all Plan provisions as necessary and to make all determinations regarding benefits payable under these American Water Employee Benefit Plans.

The following plan is fully insured:

- Life Insurance Plan

Plan Documents

In preparing this Summary Plan Description, American Water has attempted to avoid complex language and legal terms whenever possible. If a question should ever arise concerning the nature and extent of benefits under any aspect of American Water Group Insurance Plan, the actual legal Plan documents and not this Summary Plan Description, will govern.

Continuation of Health Coverage

Introduction

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. For more information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

The Plan Administrator is Senior Vice President Human Resources, American Water, 1025 Laurel Oak Road, Voorhees, NJ 08043, (856) 346-8200. The Plan Administrator is responsible for administering COBRA continuation coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone

who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator in writing within 60 days after the qualifying event occurs. You must send this notice to the Benefits Service Center, American Water, 131 Woodcrest Road, Cherry Hill, NJ 08003, along with documentation of the event.

How Long Does COBRA Coverage Last?

COBRA continuation coverage is a temporary extension of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his or her employment terminates, COBRA continuation coverage for the spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage. If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day

of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide the Plan Administrator with notice of the Social Security Administration's determination within 60 days of the latest of (1) the date of the SSA's disability determination; (2) the date of the qualifying event; (3) the date on which the qualified beneficiary would lose coverage under the Plan; or (4) the date you are provided notice of your COBRA continuation coverage rights. Notice should be sent to the Benefits Service Center, American Water, 131 Woodcrest Road, Cherry Hill, NJ 08003, along with a copy of the determination received from the Social Security Administration.

Second qualifying event extension of 18-month period of continuation coverage. If your spouse or dependent children experience another qualifying event while receiving 18 or 29 months of COBRA continuation coverage, the spouse and dependent children can get up to 36 total months of COBRA continuation coverage, if written notice of the second qualifying event is properly given to the Plan Administrator. This extension is available if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. If the second qualifying event is divorce or legal separation or the dependent child ceasing to be eligible under the Plan, written notice must be sent to the Benefits Service Center, American Water, 131 Woodcrest Road, Cherry Hill, NJ 08003, along with documentation of the second qualifying event.

How Do You Elect COBRA Coverage?

To elect continuation coverage, you must complete an election form supplied by the Plan Administrator within 60 days of the date you receive notice of your COBRA continuation coverage rights. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

How Much Does COBRA Coverage Cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of continuation coverage due to a disability, 150%) of the

cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

Special Rules for the Health Care Spending Account

COBRA coverage will consist of the Health Care Spending Account coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the Plan Year, and COBRA coverage will terminate at the end of the Plan Year. Under the special grace period rule described on page 122, if you make all required COBRA premium payments through December 31, expenses incurred for the period January 1 – March 15 of the following calendar year can be applied against any remaining balance in your Health Care Spending Account. Expenses must be submitted by April 30 of the year following the year in which COBRA coverage commenced.

Unless otherwise elected, all qualified beneficiaries who were covered under the Health Care Spending Account will be covered together for Health Care Spending Account COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health Care Spending Account annual limit and a separate premium.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Benefits Service Center, 131 Woodcrest Road, Cherry Hill, NJ 08003, (866) 888-8269, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Conversion

If any coverage (other than Health Care Spending Account coverage) being continued under COBRA terminates because the end of the

maximum continuation period has been reached, any Conversion Privilege will be available at the end of that period on the same terms as upon termination of employment or ceasing to be in an Eligible Class.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by the Family and Medical Leave Act of 1993 (FMLA). If American Water grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between the appropriate carriers and American Water.

If American Water grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue any coverage you and your eligible dependents have under the American Water Plan at the time the leave commences.

Non-FMLA leaves, and benefits during such leaves, will be administered in accordance with specific leave policies established by American Water.

At the time you request the leave, you must agree to make any contributions required by American Water to continue coverage. At the time your leave begins, you will be advised on how to make payments. American Water will continue to make its contributions toward such coverage.

If any coverage you are allowed to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

Maximum Length of Coverage

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so;

- The date American Water determines your approved FMLA leave is terminated;
- The date the coverage involved discontinues as to your Eligible Class.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

When FMLA Leave Terminates

If health care coverage terminates because your approved FMLA leave is deemed terminated by American Water, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date.

If You Return to Work

If you return to work for American Water following the date American Water determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave, provided you make request for such coverage within 31 days of the date American Water determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, you will not have a chance to re-enroll before the next Open Enrollment period.

Confidentiality of Protected Health Information

Title II of the Health Insurance Portability and Accountability Act of 1996 and the privacy regulations issued thereunder (collectively called "HIPAA") requires group health plans to protect the confidentiality of your private health information. This Plan will not use or disclose information that is protected by HIPAA ("Protected Health Information") except as necessary for treatment, payment, health care operations, and plan administration functions, or as otherwise permitted or required by law, without your written authorization. According to the law, the Plan has required all of its Business Associates to comply with the HIPAA privacy rules.

Before this Plan may disclose, or permit one of its agents or contractors to disclose, Protected Health Information ("PHI") to the Company, the Plan will require the Company to:

- certify that the information is necessary in connection with plan administration functions or other permitted functions performed or to be performed by the Company;
- amend the Plan documents and provide certification of amendment to give assurances that the Company will use and disclose the information solely in connection with such plan administration or other permitted functions; and
- not use or further disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Company without your authorization.

Under HIPAA, you have certain rights with respect to your PHI, including the right to see and copy the information, to receive an accounting of certain disclosures of the information and, under certain circumstances, to amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services if you believe your rights under HIPAA have been violated.

List of Contacts

American Water Benefit Contacts		
Carrier	**Claims Administrator**	**Phone**
Medical		
Horizon	Horizon Blue Cross Blue Shield of New Jersey PO Box 1219 Newark, NJ 07101 *www.horizonblue.com/nationalaccounts*	(800) 355-BLUE (2583)
Dental		
Aetna	Aetna P. O. Box 14094 Lexington, KY 40512-4094 *www.aetna.com*	(877) 238-6200
Vision		
EyeMed	Before enrollment: *www.enrollwitheyemed.com/access* After enrollment: *www.eyemedvisioncare.com*	(866) 939-3633
Flexible Spending Accounts		
Horizon	Horizon Blue Cross Blue Shield of New Jersey P. O. Box 1369 Newark, NJ 07101-1369 *www.horizonblue.com/fsa*	(800) 224-4426
Life and AD&D		
MetLife	Call the Benefits Service Center	(866) 888-8269
Disability		
Aetna Managed Disability	Aetna P. O. Box 14553 Lexington, KY 40412-4553 *www.aetna.com*	(800) 488-2386
Employee Assistance Program		
Carebridge	Carebridge Corporation 40 Lloyd Avenue Malvern, PA 19355 *www.mylifesource.com* *Access Code: HXSBJ*	(800) 437-0911 (610) 993-0955
Benefits Service Center		
131 Woodcrest Road Cherry Hill, NJ 08003 (866) 888-8269		

Glossary

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

Room and Board Charges

Charges made by an institution for room and board and other necessary services and supplies. They must be made regularly at a daily or weekly rate.

Skilled Nursing/Convalescent Facility

An institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from illness or injury:
  - professional nursing care by an RN, or by an LPN directed by a full-time RN, and
  - physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24-hour-a-day nursing care by licensed nurses directed by a full-time RN.
- Is supervised full-time by a doctor or RN.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mentally retarded persons, for custodial or educational care, or for care of mental disorders.
- Makes charges for services rendered.

Copay

A fee charged to a person for Covered Medical Expenses, as specified in the applicable Summary of Coverage.

Course of Treatment

A planned program of services or supplies furnished by a health care provider. The program must be:

- In connection with the diagnosis and treatment of an injury or illness, and

- Of definite duration.

Custodial Care

Services and supplies furnished to a person mainly to help him or her in the activities of daily life, including room and board and other institutional care. The person does not have to be disabled. These services and supplies are custodial care without regard to:

- By whom they are prescribed, or
- By whom they are recommended, or
- By whom they are performed.

Dentist

A legally qualified dentist, or a doctor who is licensed to do the dental work he or she performs.

Directory

A listing of Network Providers in the Service Area covered under this Plan that is available to all employees covered under the Medical Plans.

Doctor

A legally qualified, licensed doctor.

Emergency Care

The first care given in a hospital's emergency room after a sudden and, at the time, unexpected change in a person's physical or mental condition such that:

- Care cannot safely and adequately be provided other than in a hospital, or
- Adequate care is not available at the time and place it is needed.

Emergency Condition

The sudden and, at that time, unexpected onset of a change in a person's physical or mental condition which, if the procedure or treatment were not performed right away could reasonably be expected to result in:

- Loss of life or limb, or
- Significant impairment to bodily function, or
- Permanent dysfunction of a body part.

Home Health Care Agency

An agency that:

- Mainly provides skilled nursing and other therapeutic services,

- Is associated with a professional group which makes policy (this group must have at least one doctor and one RN),
- Has full-time supervision by a doctor or RN,
- Keeps complete medical records on each person,
- Has a full-time administrator, and
- Meets licensing standards.

Home Health Care Plan

A plan that provides for care and treatment of an illness or injury. The care and treatment must be:

- Prescribed in writing by the attending doctor, and
- An alternative to confinement in a hospital or skilled nursing/convalescent facility.

Hospice Care

Care given to a terminally ill person by or under arrangements with a Hospice Care Agency as part of a Hospice Care Program.

Hospice Care Agency

An agency or organization which:

- Has Hospice Care available 24 hours a day.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Provides:
  - skilled nursing services,
  - medical social services,
  - psychological and dietary counseling, and
  - bereavement counseling for the immediate family.
- Provides or arranges for other services which include:
  - services of a doctor,
  - physical or occupational therapy,
  - part-time home health aide services which mainly consist of caring for terminally ill persons, and
  - inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel which include at least:
  - one doctor,
  - one RN,

  - one licensed or certified social worker employed by the Agency, and
  - one pastoral or other counselor.
- Establishes policies governing the provision of Hospice Care.
- Assesses the patient's medical and social needs.
- Develops a Hospice Care Program to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by doctors, other than those who own or direct the Agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Utilizes volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Facility

A facility, or a distinct part of one, which:

- Mainly provides inpatient Hospice Care to terminally ill persons.
- Charges its patients.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program; this includes reviews by doctors other than those who own or direct the facility.
- Is run by a staff of doctors; at least one such doctor must be on call at all times.
- Provides 24-hour-a-day nursing services under the direction of an RN
- Has a full-time administrator.

Hospice Care Program

A written plan of Hospice Care, which:

- Is established by and reviewed from time to time by:
  - a doctor attending the person, and
  - appropriate personnel of a Hospice Care Agency.
- Is designed to provide palliative and supportive care to terminally ill persons, and supportive care to their families.

- Includes an assessment of the person's medical and social needs, and a description of the care to be given to meet those needs.

Hospital

A place that:

- Provides mainly inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of doctors.
- Provides 24-hour-a-day RN services.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home
- Makes charges for services rendered.

In-Network Care

A health care service or supply furnished by a Network Provider.

LPN

A licensed practical nurse.

Mental Disorder

An illness commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist, or a psychiatric social worker. A mental or nervous disorder includes, but is not limited to:

- Alcoholism and drug abuse
- Schizophrenia
- Bipolar disorder
- Pervasive mental developmental disorder (Autism)
- Panic disorder
- Major depressive disorder.
- Psychotic depression
- Obsessive compulsive disorder
- Mental disorders will not include alcoholism and drug abuse if a separate benefit applies to treatment of alcoholism and drug abuse.

Necessary

A service or supply furnished by a particular provider is necessary if Horizon determines that it is appropriate for the diagnosis, care, or treatment of the illness or injury involved.

To be appropriate, the service or supply must:

- Be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the illness or injury involved and the person's overall health condition,
- Be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the illness or injury involved and the person's overall health condition, and
- As to diagnosis, care, and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply that meets the above tests

In determining whether a service or supply is appropriate under the circumstances, Horizon will take into consideration:

- Information provided on the affected person's health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment;
- The opinion of health professionals in the generally recognized health specialty involved; and
- Any other relevant information brought to Horizon's attention.

In no event will the following services or supplies be considered to be necessary:

- Those that do not require the technical skills of a medical, mental health, or dental professional;
- Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any health care provider or health care facility;
- Those furnished solely because the person is an inpatient on any day on which the person's illness or injury could safely and adequately be diagnosed or treated while not confined; or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a doctor's or a dentist's office or other less costly setting.

Negotiated Charge

The maximum charge a Network Provider has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

Network Provider

A health care provider that has contracted to furnish services or supplies for a Negotiated Charge, but only if the provider is, with Horizon's consent, included in the Directory as a Network Provider for:

- The service or supply involved, and
- The class of employees of which you are a member.

Non-Occupational Illness

A non-occupational illness is an illness that does not:

- arise out of (or in the course of) any work for pay or profit, or
- result in any way from an illness that does.

An illness will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- is covered under any type of Workers' Compensation law, and
- is not covered for that illness under such law.

Non-Occupational Injury

A non-occupational injury is an accidental bodily injury that does not:

- Arise out of (or in the course of) any work for pay or profit, or
- Result in any way from an injury, which does.

Orthodontic Treatment

Any:

- Medical service or supply, or
- Dental service or supply, furnished to prevent or to diagnose or to correct a misalignment:
- Of the teeth, or
- Of the bite, or
- Of the jaws or jaw joint relationship, whether or not for the purpose of relieving pain.

Not included is:

- The installation of a space maintainer, or

- A surgical procedure to correct malocclusion.

Out-of-Network

A health care service or supply furnished by a health care provider that is not Network.

Out-of-Network Provider

A health care provider that has not contracted to furnish services or supplies at a Negotiated Charge.

Reasonable and Customary Charge

Only that part of a charge considered "reasonable" is covered. The reasonable charge for a service or supply is the lower of:

- The provider's usual charge for furnishing it, or
- The charge Horizon determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In determining the reasonable charge for a service or supply that is unusual, not often provided in the area, or provided by only a small number of providers in the area, Horizon may take into account such factors as:

- The complexity of the service or supply,
- The degree of skill needed,
- The type of specialty of the provider,
- The range of services or supplies provided by a facility, and
- The prevailing charge in other areas.

RN

A registered nurse.

Semi-Private Rate

The charge for room and board, which an institution applies to the most beds in its semi-private rooms with two or more beds. If there are no such rooms, Horizon will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Service Area

The geographic area in which Network Providers for this Plan are located, as determined by Horizon.

Terminally Ill

A medical prognosis of six months or less to live.

Totally Disabled

"Totally disabled" means that because of injury or illness:

- You are unable to engage in your customary occupation and are not working for pay or profit.
- Your dependent is unable to engage in most of the normal activities of a person of like age and sex in good health.