

**PPO PLAN
SUMMARY PLAN DESCRIPTION
for
Acme Corporation**

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No provisions of any of your benefit plans are considered a contract of employment between you and **Acme Corporation**, nor does your participation in any plan provide any guarantee of continued employment.

HOW YOUR PREFERRED PROVIDER ORGANIZATION (PPO) PLAN WORKS

Under a PPO, you may obtain care from any provider you choose. However, if you choose a provider who participates in the PPO network, your costs will be lower. Providers in the network have agreed to accept a negotiated rate as payment in full. If you receive care outside of the PPO network, the Plan benefits are based on Reasonable and Customary Charges (R&C). You must pay any coinsurance identified by the Plan and any amount billed over the R&C limits.

You can get a copy of the participating provider directory by calling 800 555 1212 or visiting www.PPOInsurance.com.

ELIGIBILITY & ENROLLMENT

To participate in the PPO plan you must belong to one of the following groups:

If appropriate, eligibility can be specified for retirees and 'other'

- All full time employees
- Spouses / Domestic Partners of all full time employees
- Children of all full time employees to age 19. Full-time students covered to age 22

Contact the plan administrator for enrollment instructions and deadlines.

If your spouse or eligible dependent also works at Acme Corporation and is eligible for medical coverage, he or she can enroll as an employee or as your dependent, but not both. If you and your spouse are both employees of Acme Corporation and eligible for medical coverage, only one of you may enroll your eligible children.

Qualified Medical Child Support Orders

The Plan also provides health care coverage for your child under the terms of a Qualified Medical Child Support Order (QMCSO)—even if you do not have legal custody of the child and the child does not depend on you for support—and whether or not any enrollment restrictions might otherwise apply for dependent coverage. If the Plan receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or a state agency may enroll the child.

Federal law requires that a QMCSO meet certain form and content requirements in order to be valid. If you have any questions or you would like a copy of the written procedures for determining whether a QMCSO is valid, please contact John Q Public 800 555 3131.

Effective Dates

Coverage Begins

Once you enroll, the date coverage begins depends on why and when you are enrolling. As long as you enroll within the timeframes required by the Plan, your coverage will begin as follows:

Event	Coverage Begins
New Hire	First of the month following date of hire
*Newly Eligible	First of the month following 60 days of service
Open Enrollment	Your coverage will begin on the first of the month that begins the new plan year.
Mid-Year Enrollment	Immediate
Marriage	If you enroll within 30 days after marriage, coverage is effective 1st of the month with proof of marriage.
Birth	If you enroll your dependent within 30 days after his or her birth, coverage will be retroactive to the date of birth.
Adoption/Placement for Adoption	If you enroll your dependent within 30 days after his or her adoption or placement, coverage will be retroactive to the date of adoption or placement.
Loss of Coverage	If you enroll within 30 days after your loss of other coverage, (60 days if you lose Medicaid or Children's Health Insurance Program (CHIP) coverage) Plan coverage is effective 45 days after termination date
Eligibility for Medicaid or CHIP contributions	If you become eligible for employee contribution subsidies from Medicaid or CHIP you may enroll within 60 days after eligibility. Plan coverage is effective immediately

If you are reinstating coverage and your previous coverage under the Plan ended due to a period of service covered under the Uniformed Services Employment and Re-employment Rights Act of 1994, your coverage is effective on the day you return to work. Waiting periods and pre-existing condition limits will be imposed only to the extent they applied before your coverage ended.

There are five (5) options with varying language for pre-existing conditions

Pre-Existing Condition Rules

The PPO plan limits coverage of pre-existing conditions. This means that any condition for which you have been diagnosed or treated, or for which you have taken medication within 12 months before your effective date of coverage, will not be covered for 90 days following your effective date.

The pre-existing condition limitation periods may be reduced by prior health care coverage as evidenced by a Certificate of Creditable Coverage.

CERTIFICATES OF CREDITABLE COVERAGE

Certificates of creditable coverage are written documents provided by a group health plan (or another source that offers health care coverage) to show the type of health care coverage a person had (e.g., employee only, family, etc.) and how long the coverage lasted. Under Federal law, most group health plans must provide these certificates automatically when a person's coverage terminates. However, if you do not receive a certificate, you have the right to request one. Certificates apply to both participants and dependents.

The primary purpose of the certificates is to show the amount of "creditable coverage" that you had under a group health plan or other health insurance coverage, because this can reduce or eliminate the length of time that any preexisting condition clause in a new plan otherwise might apply to you. The Plan will automatically give you a certificate after you lose health coverage (whether regular coverage or COBRA continuation coverage) and will make reasonable efforts to provide on the certificate the names of your dependents who were also covered. The Plan will automatically provide certificates for your dependents when it has reason to know that they are no longer receiving health coverage. In addition, the Plan will provide a certificate of health coverage for you (or your dependents) upon request if you make the request within 24 months after your coverage terminates.

CHANGING YOUR ELECTION

You may not enroll or change your election until the next annual enrollment—unless you have a qualified status change.

Qualified status changes include:

- Marriage, divorce, legal separation, or annulment of a marriage,
- Birth, adoption, or placement for adoption of a child,
- Death of an eligible dependent
- Loss of your dependent's eligibility (for example, a dependent child who no longer meets the age limitations under the plan),
- Changes in your dependent's employment status that affect the individual's coverage under a plan,
- Changes in place of residence that could affect the availability of coverage under the service area
- Changes in your or your eligible dependent's coverage (including coverage changes under Medicare, CHIP or another employer's plan). This would include changes due to an annual enrollment change, significant change in cost or coverage, or significant change in level of benefits.

Your enrollment or change in benefits must be consistent with your qualified status change and you must notify the plan administrator of any change in status within 30 days of the status change.

If you are declining enrollment for yourself or your dependents (including your spouse) because you have other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Acme Corporation group health insurance plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). These are called **Special Enrollment Events**. You must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If the Special Enrollment Event is the loss of CHIP or Medicaid coverage or if you become eligible for employee contribution subsidies from Medicaid or CHIP you may request enrollment in the plan within 60 days of the event.

For information on how to change your benefit election, contact the plan administrator.

COST

You and Acme Corporation share the cost of coverage for you and your family. You will be notified of the cost when you enroll for the first time and during annual enrollment. You pay your share of the cost on a pre-tax basis. This means your contribution is taken before most federal, state, and local taxes are taken from your paycheck. Therefore, this pre-tax deduction lowers your taxable income.

Taxation for Certain Coverage

This Plan covers same-sex spouses. However, federal law does not recognize same-sex spouses. Therefore, coverage that is available to same-sex spouses may be taxable for federal and most state income tax purposes but not taxable for MA, VT state income tax purposes.

BENEFIT SUMMARY

The chart below highlights the coverage available for many common services. This benefits summary is intended to be an overview of the services covered under the Preferred Provider Organization Plan (PPO). If you have questions about coverage under the plan, contact the claims administrator. If service is not listed, contact provider to confirm coverage.

Benefit Items	PPO In-Network	PPO Out-of-Network
Plan-Year Deductible		
Deductible - Individual	\$300	\$450
Deductible - Family	\$600	\$900
Plan-Year Out-of-Pocket Maximum		
Individual	\$1,000	\$1,000
Family	\$2,500	\$2,500
Plan Specifics		
Lifetime Maximum	\$2,000,000	\$2,000,000
Physician's Services		
Office Visit	\$30 copay, annual deductible does not apply	\$45 copay, annual deductible does not apply
Specialist Office Visit	\$30 copay, annual deductible does not apply	\$45 copay, annual deductible does not apply
Allergy Treatment/Injections	100% after satisfying the annual deductible	80% after satisfying the annual deductible
Allergy Serum (dispensed by physician in office)	100% after satisfying the annual deductible	80% after satisfying the annual deductible
Second Opinion/Consultations (provided on voluntary basis)	100% after satisfying the annual deductible	80% after satisfying the annual deductible
Surgery Performed in the Physician's Office	100% after satisfying the annual deductible	80% after satisfying the annual deductible
Preventive Care		
Routine Preventive Care for Children and Adults (including routine immunizations)	100% after satisfying the annual deductible	80% after satisfying the annual deductible
Immunizations	100% after satisfying the annual deductible	80% after satisfying the annual deductible
Mammograms, PSA, Pap Test	100% after satisfying the annual deductible	80% after satisfying the annual deductible
Emergency Care		
Physician's Office	100% after satisfying the annual deductible	100% after satisfying the annual deductible
Hospital Emergency Room	\$100 copay, annual deductible does not apply	\$100 copay, annual deductible does not apply
Outpatient Professional	100%, annual	100%, annual deductible

Benefit Items	PPO In-Network	PPO Out-of-Network
Services (Radiology, Pathology and Emergency Room Physician)	deductible does not apply	does not apply
Urgent Care Facility Services	\$100 copay, annual deductible does not apply	\$100 copay, annual deductible does not apply
Ambulance	\$100 copay, annual deductible does not apply	\$100 copay, annual deductible does not apply
Inpatient Hospital		
Inpatient Hospital Services	100% after satisfying the annual deductible	80% after satisfying the annual deductible
Inpatient Hospital Doctor's Visits/Consultations	100% after satisfying the annual deductible	80% after satisfying the annual deductible
Inpatient Hospital Professional Services	100% after satisfying the annual deductible	80% after satisfying the annual deductible
Maternity Care		
Initial Office Visit to Confirm Pregnancy	\$30 copay to confirm pregnancy. 100% for all subsequent visits. Annual deductible does not apply	\$45 copay to confirm pregnancy. 100% for all subsequent visits. Annual deductible does not apply
All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee)	100%, annual deductible does not apply	80%, annual deductible does not apply
Delivery - Facility (Inpatient Hospital/Birthing Center Charges)	100%, annual deductible does not apply	80%, annual deductible does not apply
Pre-natal vitamins	100% after satisfying the annual deductible	80% after satisfying the annual deductible

The table of benefits is quite extensive. If a provision in the table is not offered, simply leave the values blank and the benefit will be omitted from the generated document.

Women's Health and Cancer Rights Act

The Women's Health & Cancer Rights Act of 1998 requires group health plans that provide coverage for mastectomies to provide mastectomy-related benefits to Plan participants. Specifically, the legislation requires that when a covered individual receives benefits for a mastectomy and decides to have breast reconstructive surgery, the Plan must provide coverage in a manner determined in consultation with the attending physician and the patient, for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce symmetrical appearances; and
- prostheses and physical complications at all stages of the mastectomy, including lymphedemas.

These procedures will be covered the same as any other medical/surgical benefit under the Plan. Certain general coverage limitations may apply including, but not limited to, deductibles, co-insurance, co-payments and reasonable and customary charges.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay of no more than 48 hours (or 96 hours).

WHAT IS NOT COVERED

Not all services are covered by the Plan. Limitations and exclusions apply even if a qualified practitioner has performed or prescribed services that are limited or excluded under the plan.

The Plan does not provide benefits for the following:

- Services received before your coverage took effect.
- Expenses incurred while you were committing a crime or attempting to commit a criminal act.
- Services which are not provided.

CLAIMS

A claim for benefits is a request for plan benefits made by a covered employee/dependent or their representative, that complies with the plan's reasonable procedure for making benefit claims.

Claims are divided into four categories:

- **Pre-Service Claims**, which are claims for benefits where approval is required before you get care. Benefits will not be denied if it is not possible to get advance approval or if the process would jeopardize your life or health.
- **Urgent Care Claims**, which are claims for care or treatment, as determined by the Plan, that would:
 - Seriously jeopardize your life, health or ability to regain maximum function if normal pre-service standards were applied; or
 - Subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a physician with knowledge of your condition.
- **Concurrent Care Claims**, which are claims that are reconsidered after initially approved (such as recertification of the number of days of an inpatient stay) and the reconsideration results in reduced benefits or a termination of benefits.
- **Post-Service Claims**, which are claims for benefits where you have already received the services for which the claim is being submitted.

Filing a Claim

Many providers will file claims for you. If your provider does not, follow the steps listed in this section. If a claim is denied, in whole or in part, there is a process you can follow to have your claim reviewed.

All network providers and many other providers will submit claims for you. Be sure to show your ID card to your provider so they will know where to submit the claim. If your provider does not submit your claim for you, then you must do so. When you need to

submit a claim, follow the steps listed below to make sure your claim is processed as quickly as possible:

Step 1: When you receive covered services or supplies, be sure your bill or statement shows the:

- Provider's name and address;
- Full name of the patient (no nicknames);
- Date of service;
- Charges, listed separately for each service;
- Description of services;
- Diagnosis; and
- Nine-digit identification number from your ID card.

Step 2: Obtain the appropriate claim form from your employer or the Plan.

Step 3: Complete the claim form.

- Make sure to provide all requested information.
- Use a separate claim for each member.
- Review the form to insure accuracy. Incomplete forms will be returned to you, which will cause a delay in payment.
- Make a copy of the claim for your records; originals cannot be returned to you.
- Be sure to sign and date the form.

Step 4: Submit the form to the address listed on the form.

- Be sure to enclose the original bill or statement with the form; cash register receipts, cancelled checks and money order stubs are not acceptable.
- If you or your dependent have coverage under another plan (including Medicare), be sure to include information on the other coverage, including any Explanation of Benefits (EOB) if the other plan paid first.

Claim Filing Deadlines

Claims can be filed by you, your dependent, your beneficiary or someone authorized to act on your or their behalf. However, claims should be submitted as soon as possible. If a claim is not submitted by **90 days following date of service** it will be denied.

Assignment of Benefits

“Assigning” benefits means that you authorize the Plan to pay your provider directly. You must provide a written, signed authorization to assign benefits. Once benefits are

assigned, all payments will then be made directly to the provider, unless you or dependent later notify the Plan, in writing, to make payment directly to you.

Explanation of Benefit (EOB)

Whenever a claim is processed, you will receive a printed summary, called an Explanation of Benefits (EOB). An EOB is an itemized statement that shows what action has been taken on a claim; it is not a bill. It is provided to help you understand how expenses were paid and that the information received by the Plan was correct. An EOB is for your information and files. When you receive an EOB, you should review it to verify that it is accurate; be sure to report any inaccuracies.

If you receive an EOB from other coverage, be sure to provide it along with your related claim.

Claim Decisions

Once your claim is submitted, it will be reviewed to determine if you are eligible for benefits and calculate the amount of benefits payable, if any. All claims are processed promptly, when complete claim information is received.

Generally, the following claims procedures apply to claims made under this Plan. However, to the extent that these procedures are inconsistent with the claims procedure contained in the policies, contracts, or other written materials of the Plan, the claims procedure in such materials shall supersede this procedure as long as such other claims procedure complies with government regulations:

- **Pre-Service Claims.** An initial determination will be made within 15 days after your claim is received.
 - If more time is needed due to matters beyond the Plan's control, you will be informed, within this 15-day deadline, that an extension of up to 15 additional days is needed.
 - If more information is needed to process your claim, you will be notified within 15 days of receipt of the claim. You will then have up to 45 days to provide the requested information. You will be notified of a determination within 15 days after this additional information is received.
- **Pre-Service Urgent Care Claims.** A determination will be made within 72 hours from receipt of the claim. Notice of a decision on an urgent care claims may be provided orally within 72 hours and then confirmed in writing within three days after the oral notice. If more information is needed to process the claim, you will be notified within 24 hours of receipt of the claim. You will then have up to 48 hours to respond. You will be notified of a determination within 48 hours of the later of receipt of the additional information or the end of the 48-hour period for you to provide the additional information
- **Concurrent Care Claims.** A determination will be made as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated if possible.

- If you ask for an extension of approved urgent care treatment, the Plan will act on your request within 24 hours after receiving it, as long as the claim is received at least 24 hours before the approved treatment ends.
- If a concurrent care claim does not involve urgent care treatment or is filed less than 24 hours before the previously approved period or number of treatments runs out, the claim will be processed according to the type of claim involved.
- **Post-Service Claims.** An initial determination will be made within 30 days of receipt of the claim.
 - If more time is needed due to matters beyond the Plan's control, you will be informed, within this 30-day deadline, that an extension of up to 30 additional days is needed.
 - If more information is needed to process your claim, you will be notified within 30 days of receipt of your claim and you then have up to 45 days to provide the requested information. You will be notified of a determination within 15 days after this additional information is received.

If an extension is needed, the extension notice will include the reasons for the extension and the date a decision is expected.

If a Claim Is Denied

If a claim is denied (in whole or in part), you (or your beneficiary) will receive a written notice, within the timeframes described above, that includes:

- The specific reason(s) for the decision;
- Reference to the Plan provision(s) on which the decision was based;
- A description of any additional information or material needed to properly process the claim and an explanation of why it is needed;
- A copy of the Plan's review procedures and the time periods that you must comply with to request an appeal decision, including:
 - A description of the expedited review process for urgent care claims, if applicable; and
 - A statement that you may bring a lawsuit under ERISA after appealing the denial; and
- If applicable, a statement that a copy of:
 - Any rule, guideline, protocol or similar criteria on which the claim is denied is available at no cost upon request, if applicable; or
 - Any scientific or clinical judgment relating to medical necessity, experimental treatment or similar exclusion or limit on which the claim is denied is available at no cost upon request.

Appealing a Denied Claim

If a claim is denied or you disagree with the amount of the benefit, you may have the initial decision reviewed. You must follow and exhaust the Plan's appeals procedure before you file a lawsuit under ERISA (the federal law governing employee benefits) or initiate proceedings before any administrative agency.

In general, written requests for an appeal should be sent as soon as possible. If a claim is denied or if you are otherwise dissatisfied with a Plan determination, a written appeal must be filed within 180 days from the date of the decision. . For urgent care claims, the appeal may be made orally or sent by fax.

Your written appeal should explain the reasons you disagree with the decision and any other information requested in the denial notice. When filing an appeal you may:

- Submit additional materials, including comments, statements or documents;
- Request to review all relevant information (free of charge);
- Request a copy of any internal rule, guideline, protocol or other similar criteria on which the denial was based; and
- Request a copy of any explanation of the scientific or clinical judgment on which the denial was based if the denial was based on medical necessity, experimental treatment or similar exclusion or limitation.

Appeal Decisions

If an appeal is filed on time, following the required procedures, a new, full and independent review of the claim will be made. The new decision will not consider the initial decision. An appropriate Plan fiduciary will conduct the review and the decision will be based on all information used in the initial determination as well as any additional information provided. If the request for review involves a claim for benefits that are provided by the insurance company, that company will make the review and final decision.

A determination on appeal will be made within certain timeframes for the different types of claims as follows:

- **Pre-Service Claims.** A determination will be made within 15 days of receipt of the appeal.
- **Urgent Care Claims.** A determination will be made with 72 hours of receipt of the appeal.
- **Concurrent Care Claims.** A determination will be made, if possible, before termination or reduction of the benefit.
- **Post-Service Claims.** A determination will be made within 30 days of receipt of the appeal.

Written notification of the decision will be provided, in writing, within five days after a determination is made. However, oral notice of a determination on an urgent care claim

may be provided sooner. The written notice will include all required information, including information on how to obtain a second level appeal and a statement indicating that the participant may bring a lawsuit under ERISA after the denial of an appealed claim.

Final Appeal

If you are dissatisfied with the claims administrator's decision on your initial appeal, you may request a second and final review. The final review follows the same process as your initial appeal.

If your claim involves Urgent Care, a request for an expedited appeal may be submitted orally or in writing. All necessary information, including the plan's benefit determination on review, shall be transmitted between the claims administrator and the claimant by telephone, facsimile, or other available similarly expeditious method. In general, urgent care guidelines apply when you need to have the process expedited to prevent serious risk to your health, life or ability to regain maximum functionality, or in the opinion of your physician to prevent severe pain that cannot be managed without the requested services. The decision on expedited appeals will be communicated orally within 72 hours and will be followed up in writing.

Authorized Representatives

You may designate another person as your authorized representative for filing a claim. Except in the case of an urgent care claim, this designation must be in writing. Unless your authorization states otherwise, all notices regarding your claim will be sent to your authorized representative and not to you. A health care provider that has knowledge of your medical condition may act as your authorized representative for urgent care claims.

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide written notification authorizing this representative, and comply with the Plan procedures. Written notification must be received before a determination is made. You or your representative may review the pertinent records and documents.

You may have, at your own expense, legal representation at any stage of the review process. If any Plan provision is determined to be unlawful or illegal, the illegality will apply only to the provision in question and will not apply to any other Plan provisions

Medical Judgments

If a claim or appeal is denied based on a medical judgment, the Plan will consult with a health care professional who:

- Has appropriate training and experience in the field of medicine involved in the judgment; and
- Was not consulted (or does not report to the person who was consulted) in

connection with the original denial of the claim.

You may ask for the identity of any medical experts the claims administrator consulted when deciding about your claim.

Incompetence

If the Plan determines that a person entitled to benefits is unable to care for his or her affairs because of illness, accident or incapacity (either physical or mental), payment that would otherwise be made to that person will be made to that person's duly appointed legal representative. If no legal representative has been appointed, payment will, at the discretion of the Plan, be made to that person's spouse, child or such person who has care and custody of that person.

Release of Information

By participating in the Plan, you authorize physicians, hospitals and other providers to provide the Plan, upon request, with information relating to services that you are or may be entitled to under the Plan for treatment, payment and health care operations. This authorization allows the Plan to examine records with respect to the services and to provide information requested. All information related to treatment remains confidential except for the purpose of determining rights and liabilities under the Plan.

COORDINATION OF BENEFITS (COB)

Benefits under the Plan are coordinated with benefits provided by other plans under which you are also covered. For the purpose of coordinating benefits, a plan is one which covers medical or dental expenses and provides benefits or services. Each plan will determine what is an allowable expense according to its own provisions.

Right of Recovery

The Plan may have the right to reimbursement for benefits provided or paid for which you were not eligible under Plan terms. Reimbursement may be due and payable immediately upon Plan request. In addition, the Plan may have the right to reduce or refuse payment of future benefits to recover any reimbursement. The acceptance of premiums or other fees or the providing or paying of benefits by the Plan would not constitute a waiver of the Plan's rights to enforce this provision in the future. This provision would be in addition to, and not instead of, any other remedy available to the Plan at law or in equity.

Subrogation

If you incur expenses due to a bodily injury or illness caused by negligence or wrong of a third party and benefits are payable under this Plan, you will receive benefits.

However, the Plan may have the right to recover any payment it made on behalf of any eligible member from any liable party except against insurers on policies of insurance issued to or in the name of that person. You must execute the necessary documents or perform any other act required to secure this Plan right.

If any amounts are recovered from the third party, whether by judgment, settlement or otherwise, you, your dependents or your personal representative may have to reimburse the Plan for the total amount of benefits paid. The amount to be reimbursed will not exceed the proceeds of any recovery after the deduction of reasonable and necessary expenditures, including attorney's fees, incurred in effecting such recovery.

WHEN COVERAGE ENDS

Coverage terminates on the earliest of the following:

For Employees

- The date the Plan terminates.
- The end of the period for which any required contribution was due and not paid.
- The first of the month after the date you are no longer a member of an eligible class of employees.
- The first of the month after the month in which you terminate employment with your employer.
- The first of the month after the month in which you retire.

For Dependents

- The first of the month after the date your coverage terminates.
- The first of the month after the month in which he or she no longer meets the definition of a covered dependent as defined in the Plan or required under state law.

When coverage ends, you will automatically be issued a Certificate of Creditable Coverage by the plan administrator. A certificate of Creditable coverage may also be requested within 24 months of when your coverage terminates. This certificate will describe the period during which you were a plan participant. If you (or your dependent, ends, the new plan must reduce any pre-existing condition exclusion period by the length of your creditable coverage.

Continuation of Health Care Benefits - COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, you and your dependents may be eligible to temporarily extend group health care coverage under the Medical Plan. Both you and your dependents should take the time to read this section carefully. Your rights and obligations under the law are summarized below. Please note COBRA does not provide for continuation of coverage to domestic partners.

In general, in order to elect continued coverage, you and your dependents must have been covered under the Plan on the day before the event that caused coverage to

terminate. However, any children born to or placed for adoption with you while you are covered through COBRA will automatically be covered under the Plan you elect.

In order to continue coverage, you or your covered dependents must pay the full cost of that coverage (your share, if any, plus the company's share) plus a 2% administrative fee. Your contributions must be made on an after-tax basis and will be subject to an additional 2% administrative fee.

COBRA Qualifying Events

Continued coverage under the Medical Plan can be purchased as follows:

- If you are an active employee covered by the plan, you may elect COBRA continuation coverage if your coverage under the plan is lost because:
 - Your hours of employment are reduced, or
 - Your employment terminates (other than for gross misconduct).
- If you are a covered spouse of a covered active or former employee, you may elect COBRA continuation coverage for yourself if your coverage under the plan through your spouse is lost for any of these reasons:
 - The covered employee dies.
 - The covered employee's hours of employment are reduced or employment terminates (other than due to gross misconduct).
 - You are divorced or legally separated from your spouse, or
 - The covered employee becomes entitled to coverage under Medicare.
- If you are a covered dependent child of a covered active or former employee you may elect COBRA continuation coverage if coverage under the plan is lost for any of these reasons:
 - The covered employee dies
 - The covered employee's hours of employment are reduced or employment terminates (other than due to gross misconduct).
 - Your parents divorce or legally separate.
 - You cease to be a dependent child under the terms of the Plan, or
 - The covered employee becomes entitled to coverage under Medicare.

If you or your dependents purchase continue coverage, the coverage will be the same as the coverage you had on the day before the qualifying event.. However, if the Plan covering similarly situated active employees changes, those changes will also apply to your continuation coverage.

COBRA Eligibility

The Company is responsible for notifying the plan administrator—within 30 days of the event—of your right to purchase continued coverage through COBRA following a change in your employment status with the company, your entitlement to Medicare or your death.

If you become disabled or there is a change in your spouse's or dependent's status because you become divorced or legally separated, or your child no longer meets the

eligibility requirements, you are responsible for notifying the plan administrator within 60 days of the event.

Within 14 days after the plan administrator is notified in writing that a COBRA qualifying event has occurred, the plan administrator will notify you and your dependents of your rights to elect continuation coverage. You then have 60 days from the later of the day the claims administrator mails notice of your COBRA election rights to you and the day your regular coverage ends to return your written COBRA election to the claims administrator. If you elect to continue coverage, you have 45 days from the date of your election to make your first payment. Once your continued coverage begins, the claims administrator must receive your monthly payments before the start of each month.

You do not have to provide evidence of good health to elect continuation coverage.

If you change your marital status or if you, your spouse or your dependent change addresses, notify the plan administrator immediately.

COBRA Continuation Period

COBRA allows you to keep your coverage for up to:

- Eighteen months if your coverage is lost because your employment terminates or your work hours are reduced
- Thirty-six months if coverage is lost because of death, divorce, legal separation, or when a child ceases to be a dependent child
- If you have an 18 month qualifying event, and the Social Security Administration determines that you (or your spouse or dependent child, if applicable) are disabled at any time during the first 60 days of the continuation health coverage period then your continuation coverage period as well as your spouse's and any dependent's continuation periods may be extended from 18 months to 29 months.

If you recover (are no longer disabled) you must notify the plan administrator within 30 days. If you recover within the initial 18-month COBRA period, you may keep your continuation coverage for the remainder of the 18-month period. Should you recover in the 19th through the 28th month, your continuation coverage will cease at the end of the month in which you are determined to no longer be disabled. You may be charged up to 150 percent of the total cost of coverage for the 11-month extension period.

- If during an 18 month event, a second qualifying event takes place that entitles your spouse (or dependent child, if applicable) to continuation health coverage, your spouse's continuation coverage (or dependent child's continuation coverage, if applicable) may be extended by another 18 months. You must make sure that the plan administrator is notified of the second qualifying event within 60 days of the second qualifying event. In no event will your spouse's health continuation coverage (or your dependent child's health continuation coverage, if applicable) extend for more than a total of 36 months from the date of the initial event.

Ending COBRA Continuation Coverage

Your COBRA continuation coverage will end for any of the following reasons:

- The company no longer provides group health coverage to any of its employees
- You do not pay the premium for your coverage
- You become entitled to Medicare,
- In the case of a 29-month extension due to disability, a determination is made that the individual is no longer disabled (after the first 18 months) or
- You become covered under another group health plan, unless there is a pre-existing condition exclusion as explained below.

If you become covered under another group health plan that excludes coverage for pre-existing medical conditions, you may keep your COBRA coverage until the earlier of:

- The date the pre-existing medical condition exclusion expires, or
- The date your continuation coverage eligibility period ends.

When COBRA coverage ends, you will automatically be issued a certificate of creditable coverage by the plan administrator. A certificate of medical coverage may also be requested within 24 months of when your coverage terminates. This certificate will describe the period during which you were a plan participant and the length of your COBRA coverage. If you (or your dependent, if applicable) participate in another group health plan within 63 days after your COBRA coverage ends, the new plan must reduce any pre-existing condition exclusion period by the length of your creditable coverage.

When COBRA coverage ends, you must also be given the opportunity to enroll in an individual conversion plan provided by the company.

Same-sex spouses and domestic partners are not eligible for certain benefits under federal law, such as COBRA continuation coverage. Information regarding continuation coverage for same-sex spouses and domestic partners is available from the Plan Administrator upon request.

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Federal law requires the Plan to offer to continue coverage to you and/or your dependents if you are absent due to service in the uniformed services. Coverage may continue for up to 24 months after the date you are first absent due to uniformed service.

Eligibility

You are eligible for continuation under USERRA if you are away from work because of voluntary or involuntary service in the Armed Forces, Army National Guard, Air National Guard, the commissioned corps of the Public Health Service, or any other category of persons designated by the President of the United States of America in a time of war or national emergency. Service includes absence for active duty, active duty training, initial active duty training, inactive duty training, full-time National Guard duty and for the

purpose of an examination to determine fitness for duty. Any of your dependents who are covered under the Plan immediately before the date your military service begins may also elect continuation under USERRA.

Premium Payment

If you elect to continue Plan coverage under USERRA, you must pay the applicable cost of coverage. If you are absent for 30 days or less, the cost will be the amount you would otherwise pay for coverage as an active employee. For absences exceeding 30 days, the cost may be up to 102% of the cost of coverage under the Plan. This includes your share and any portion previously paid by Acme Corporation.

Duration of Coverage

Elected continuation coverage under USERRA will continue until the earlier of:

- 24 months beginning the first day of absence from employment due to service in the uniformed services; or
- The day after you do not apply for or return to employment as required by USERRA, after completion of a period of service.

Under federal law, the period of coverage available under USERRA will run concurrently with the COBRA period available to an employee and/or eligible dependents.

FAMILY AND MEDICAL LEAVE ACT

You may be able to continue coverage under the Plan as provided by the Family and Medical Leave Act (FMLA). The FMLA applies if the Plan Sponsor has 50 or more employees. If you have been employed at least one year and worked at least 1,250 hours within the previous 12 months, you may continue coverage for up to 12 weeks of unpaid leave for:

- The birth of your own child.
- The placement of a child with you for the purpose of adoption or foster care.
- To care for a “seriously ill” spouse, child or parent.
- A serious health condition rendering you unable to perform your job.
- A “qualified exigency” as defined by the Department of Labor caused by a spouse, son, daughter or parent being on active duty or notified of an impending call to active duty status in support of a contingency operation.

In addition, an employee who is a spouse, child, parent or nearest blood relative of a service member to take up to 26 weeks of FMLA leave to care for service member if he or she has a serious illness or injury.

If you take an approved FMLA leave, you may continue to receive Plan coverage for yourself and your covered dependents. Coverage will terminate at the end of your FMLA leave period if you do not return from leave, or on the date you give notice that you will not be returning from FMLA leave, and you will be eligible for COBRA continuation coverage (as described above). To continue Plan coverage during unpaid

FMLA leave, you must continue to pay your share of the premium. You should contact the plan administrator to make arrangements for premium payments during unpaid FMLA leave. If you do not continue your Plan coverage or other types of coverage during unpaid FMLA leave, your coverages will be reinstated when you return from FMLA leave. For additional information about Plan coverage during FMLA leave, contact the plan administrator.

If you choose to continue coverage during the leave, you will be given the same health care benefits that would have been provided if you were working, with the same premium contribution ratio. If your payments are more than 30 days late, the Plan Administrator will send written notice to you. The notice will state that coverage will be terminated. It will also give the date of the termination if payment is not received by that date. This notice will be mailed at least 15 days before the termination date.

If your coverage under this health plan is discontinued during FMLA leave for any reason your coverage will be restored when you return to work to the same level of benefits as those you would have had if the leave had not been taken and the premium payment(s) had not been missed. This includes coverage for eligible dependents. You will not be required to meet any initial qualification requirements when returning to work. This includes: new or additional waiting periods; waiting for an open enrollment period; or passing a medical exam to reinstate coverage.

For additional information about health plan benefits during FMLA leave, contact the Plan Administrator

RIGHTS UNDER ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA)

Receive Information About Your Plan and Benefits

ERISA provides that all plan participants shall be entitled to:

- 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 operations 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

You are entitled to continue health care coverage for yourself, your spouse, and your dependents if there is a loss of group health plan coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for this coverage. You should review this Summary Plan Description and the documents governing the Plan on the rules governing your continuation of coverage rights under COBRA. Same-sex spouses are not considered qualified beneficiaries under COBRA.

Exclusionary periods of coverage for preexisting conditions may be reduced or eliminated, if you have previous creditable coverage under another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan when:

- you lose coverage under that plan,
- you become entitled to elect COBRA continuation coverage,
- your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, any pre-existing condition exclusions would apply.

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, your union, 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. However, if the Plan fails to comply with a plan provision in a single situation, this will in no way waive the Plan's ability to enforce that provision in the future.

Enforce Your Rights

If your claim for a welfare 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 which 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 domestic relations order or 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 Benefit Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. Contact information for local EBSA offices can be found at www.dol.gov/ebsa.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration at 1-800-998-7542.

Agent for Service of Legal Process

Legal process may be addressed to Plan Administrator.

The Plan Administrator

The Plan Administrator is responsible for interpreting plan provisions, resolving issues of fact and making determination regarding eligibility benefits. The decisions of the Plan Administrator in all matters relating to the Plan will be final and binding.

No person may bring an action against the Plan Administrator in a court of law unless the claims appeal procedures have been exhausted and a final determination is made by the Plan Administrator. A review by a court of law will be limited to the facts, evidence and issues presented to the Plan Administrator during the appeal procedure. Facts and evidence that become known to you, your dependent, your beneficiary, or another interested person after having exhausted the appeals procedure will be brought to the Plan Administrator's attention for reconsideration of the appeal. Issues not raised with the Plan Administrator during the initial appeal will be deemed waived. Likewise,

the Plan Administrator's decision will be upheld unless it is found to be arbitrary and capricious.

While the company intends to continue the benefits and policies described in this booklet, the Plan Administrator reserves the right to change, modify or discontinue the Plan at its discretion and at any time. In addition this Summary Plan Description should not be considered a contract of employment or a guarantee of a particular benefit.

Summary of HIPAA Privacy Rights

A federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires group health plans to protect the confidentiality of your private health information. The Plan and Acme Corporation, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as otherwise permitted or required by applicable law. By law, the Plan requires all of their business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Acme Corporation.

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

To the extent required by applicable law, the Plan will maintain a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact the Plan Administrator. If you have questions about the privacy of your health information, or if you wish to file a complaint under HIPAA, you should contact the insurer or the Plan's Privacy Officer

PLAN INFORMATION

Acme Corporation	
Plan Name	Acme Corporation PPO Plan for Active Employees
Plan Number	123456
Plan Sponsor	Plan Sponsor of America, Main Street USA
Plan Sponsor Tax ID Number	12-123456
Plan Administrator	Plan Administrator, Main Street USA
Claims Administrator	Claims Administrator, Main Street USA
Agent for Legal Service	Agent for Legal Services, Main Street USA
Plan Fiduciary	Fiduciary Bank and Trust is the named fiduciary for the Plan, as defined by ERISA. The fiduciary acts on your behalf to make sure the Plan is administered fairly, honestly, and in accordance with legal standards and the terms of the plan document.
Plan Type	This plan is an employee welfare plan offering medical coverage.
Plan Year	January 1, 2009

Plan Funding	Self Insured – General Assets: Claims and covered benefits are from the company's general assets. The company has an administrative services contract with a third-party administrator to decide on and process claims.
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This document together with any descriptive materials received from the claims administrator and Trust Document as required represents the plan as a whole and supersedes any previous versions of this document.

This booklet contains a summary in English of your plan rights and benefits under the Plan. If you have any difficulty understanding any part of this booklet, please contact the Plan Administrator during standard business hours.

DEFINITIONS

The list of definitions below is a general list of commonly used terms and not intended to be specific to this summary plan description only. Therefore, certain terms listed here may not be used in this SPD.

BRAND NAME DRUG

The trademark name of a prescription drug.

CLAIMS ADMINISTRATOR

The claims administrator reviews and pays claims on behalf of the plan. Claims administrators are typically insurance companies or third party administrators.

COINSURANCE

The percentage of covered services for which you are responsible after you meet the annual deductible.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

COBRA provides participants the opportunity to continue coverage for a specified period of time when it would have otherwise been terminated.

DEDUCTIBLE

The deductible is the amount you must pay each year out of pocket before the Plan will begin to pay benefits.

GENERIC DRUG

A chemical copy of a brand-name prescription drug.

PPO

A PPO, or Preferred Provider Organization, is a group of hospitals and physicians that have agreed to accept a negotiated fee as payment in full for their services.

QUALIFIED CHANGE IN STATUS

A qualified change in status is a life event such as marriage, divorce or birth of child. . Health plans that are funded in whole or in part by pre-tax employee contributions are governed by IRS regulations that indicate that a participant may only change his/her benefit plan election during annual enrollment unless they have a qualified change in status and their election change must be consistent with the qualified change in status. All changes must be made within a pre-determined period of time of the qualified change as determined by the Plan Administrator.

QUALIFIED EXIGENCY

A qualified exigency is defined by the Department of Labor as an emergency arising out of one of the following categories: (1) short-notice deployment; (2) military events and related activities; (3) childcare and school activities (4) financial and legal arrangements; (5) counseling, (6) rest and recuperation (7) post-deployment activities and (8) additional activities not encompassed in the other categories, but agreed to by the employer and employee.

QUALIFIED PRACTITIONER

A qualified practitioner who is a professional licensed by the appropriate state agency to diagnose or treat a bodily injury or sickness, and who provides services within the scope of that license.

QMCSO

A medical child support order, approved by the Plan Administrator, that provides for health care coverage and allocation of responsibility for the payment of costs for health care coverage for a child of an employee.

R&C

R&C is short for Reasonable and Customary. Reasonable and Customary refers to the most common charge made by physicians, surgeons, providers or practitioners of similar experience for a similar procedure in a particular geographic area.