ACME America, Inc. Flexible Benefit Plan 2024

Plan Document and Summary Plan Description (SPD)

Effective Date 10

Eligible Employees 10

FULL & PART TIME EMPLOYEES 10

INPATRIATES 10

Eligible Dependents 11

ELIGIBLE SPOUSE 11

QUALIFIED DOMESTIC PARTNER 11

QUALIFIED DOMESTIC PARTNER – INCOME TAXES 11

Tax and Imputed Income 11

Federal & State Tax Treatment 11

California Employees 11

QUALIFIED DOMESTIC PARTNER – FEDERAL TAX DEPENDENT 11

ELIGIBLE CHILDREN 12

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) 13

ACME EMPLOYEES IN THE SAME FAMILY 13

RIGHT TO RESCIND COVERAGE 13

Employee Cost To Participate 14

ACME'S COST SUBSIDY "CREDITS" FOR LIFE/AD&D AND LONG TERM DISABILITY 14

Enrollment Information 14

MINIMUM REQUIRED COVERAGE 14

DEFAULT COVERAGE 15

DECLINING OR "WAIVING" COVERAGE 15

When Coverage Begins 15

EFFECTIVE DATE OF CHANGE 15

Pre-Existing Conditions 16

Qualified Family Status Change (FSC) Changes 16

CONSISTENCY RULE 16

EFFECTIVE DATE OF BENEFIT CHANGES 16

LIST OF QUALIFIED FAMILY STATUS CHANGES 17

SPECIAL ENROLLMENT CIRCUMSTANCES 17

NEWBORN AND OTHER NEWLY ACQUIRED CHILDREN 17

REPORTING A QUALIFIED FAMILY STATUS CHANGE 17

Open Enrollment 18

Medical Plans 18

MEDICAL PLANS - SERVICE AREAS 18

UnitedHealthcare Medical Plans 18

PROVIDER NETWORKS 18

Provider Network Names 19
Services Without a Viable Provider Network 20
Eligible Expenses 20
Advocacy Services 22
Health Services from Non-Network Providers Paid as Network Benefits 22
Network Provider Termination 22
UnitedHealthcare - HSA Medical Plan 23
High Deductible Health Plan (HDHP) 23
Health Savings Account (HSA) 23
ACMEs HSA Contribution (Seed) 23
HSA Personal Contributions 24
UnitedHealthcare - PPO Medical Plans 24
UHC Premium PPO Plan 24
UHC Medium PPO Plan 25
UnitedHealthcare – EPO Medical Plan 25
UnitedHealthcare - Harvard Pilgrim Passport Medical Plan 25
UnitedHealthcare - Out of Area Medical Plans 26
UnitedHealthcare Medical Plans - Prior Authorization 26
Prior Authorization – Who is Responsible? 26
Covered Health Services Requiring Prior Authorization 26
UnitedHealthcare - Health Advocacy and Support Programs 27
NURSELINE℠ - SPEAK WITH A NURSE 28
DEDICATED NURSE ADVOCATES (DNA) 28
COMPLEX AND CHRONIC CONDITIONS 28
DIABETES MANAGEMENT PLUS THROUGH LIVONGO 28
MATERNITY SUPPORT PROGRAM 29
NEONATAL RESOURCE SERVICES (NRS) 29
MYUHC.COM 29
HEALTH4ME®: UNITEDHEALTHCARE MOBILE APP 29
RALLY: ONLINE HEALTH AND WELLNESS TOOL 30
EMPLOYEE ASSISTANCE PROGRAM (EAP) 30
EAP Benefits and Limits 30
EAP Online Resources 30

EAP Cost Of Benefits 30

Kaiser Permanente HMO Plans 30

Covered Health Services - UnitedHealthcare Medical Plans 31

List of Covered Health Services (In Alphabetical Order) 31

ACUPUNCTURE 31

ALLERGY TESTING 31

ALLERGY TREATMENT 31

AMBULANCE SERVICE – AIR AND GROUND (EMERGENCY) 31

AMBULANCE SERVICE – AIR AND GROUND (NON-EMERGENCY) 31

ANESTHETICS AND OXYGEN 32

ARTIFICIAL LIMBS AND EYES 32

AUTISM SPECTRUM DISORDER (AUTISM) 32

AUTISM – COVERED HEALTH SERVICES (MEDICAL) 32

AUTISM – COVERED HEALTH SERVICES (MENTAL HEALTH) 32

BIRTH CONTROL DEVICES/ORAL CONTRACEPTIVES 33

BIRTHING CENTER 33

BREAST PUMPS 33

CANCER RESOURCE SERVICES 34

CELLULAR AND GENE THERAPY 34

CHIROPRACTIC CARE 34

COCHLEAR IMPLANTS 34

CLINICAL TRIALS 34

CONTRACEPTION METHODS AND COUNSELING 34

CONVALESCENT CARE 35

CRANIAL BAND/HELMET 35

DENTAL SERVICES – ACCIDENTAL ONLY 35

DENTAL SURGERY ANESTHESIA – ACCIDENTAL ONLY 35

DOCTOR (PHYSICIAN) OFFICE VISITS 36

DURABLE MEDICAL EQUIPMENT (DME) 36

EMERGENCY SERVICES 36

Emergency Notification Requirement 37

Emergency Services (Non-US) 37

Non-Emergency Services (Non-US) 37

ENTERAL NUTRITION 37

FAMILY PLANNING 38

FERTILITY 38

GENDER DYSPHORIA 39

GYNECOMASTIA 42

HEARING AIDS 42
HOME HEALTH CARE 42
HOSPICE CARE 42
HOSPICE CARE AGENCY 43
HOSPITAL 43
HYPERHIDROSIS 43
IMMUNIZATIONS 43
INJECTIONS IN A PHYSICIAN'S OFFICE 44
MAMMOGRAMS 44
MATERNITY CARE 44
MENTAL HEALTH BENEFITS 44
Mental Health – Medical Plan Coverage 45
MENTAL HEALTH SERVICES FOR AUTISM SPECTRUM DISORDER 45
MENTAL HEALTH, NEUROBIOLOGICAL DISORDERS, AND SUBSTANCE-RELATED AND ADDICTIVE DISORDERS SERVICES45
Covered Mental Health Services 45
What is Covered Under Mental Health Services 45
Substance-Related and Addictive Disorders – Covered Health Services 46
NON-OCCUPATIONAL INJURY OR DISEASE 48
NUTRITIONAL COUNSELING 48
OBESITY SURGERY 48
ORAL SURGERY 49
ORAL SURGERY ANESTHESIA 49
ORTHOGNATHIC SURGERY 49
ORTHOTICS 49
OSTOMY SUPPLIES 50
OUTPATIENT PRE-ADMISSION TESTING 50
OUTPATIENT SURGERY, DIAGNOSTIC, AND THERAPEUTIC SERVICES 50
OUTPATIENT - LAB, X-RAY AND DIAGNOSTIC 50
OUTPATIENT - LAB, X-RAY AND MAJOR DIAGNOSTICS - CT, PET SCANS, MRI, MRA AND NUCLEAR MEDICINE 51
OUTPATIENT SURGERY 51
OUTPATIENT THERAPEUTIC 51
PALLIATIVE CARE SERVICES 51
PHYSICIAN FEES FOR SURGICAL AND MEDICAL SERVICES 52
PHYSICIAN'S OFFICE SERVICES 52

PREIMPLANTATION GENETIC TESTING 52
PRESCRIPTION DRUGS 53
OptumRx 53
ID Card 53
Network & Non-Network Pharmacies 53
Prescriptions – Category Tiers 54
Preferred Drug List (PDL) and Tier Changes 54
PDL Tier Factors 54
Rebates and Other Discounts 55
Prescriptions – Plan Coverage 55
Prescriptions - HSA Medical Plan 56
Prescriptions – Covered Health Services 56
Maintenance Medications 56
Specialty Medications 57
Prior Authorization Requirements 58
Prior Authorization Instructions 59
PREVENTIVE CARE 60
Network Preventive Care 60
Preventive Care Services (Adults) 60
Preventive Care Services (Women) 61
Preventive Care Services (Children) 61
PRIVATE DUTY NURSING 61
PROSTHETIC DEVICES 62
RADIOLOGIST, ANESTHESIOLOGIST AND PATHOLOGIST SERVICES (RAPS) 62
RECONSTRUCTIVE PROCEDURES 62
REHABILITATION SERVICES AND HABILITATIVE SERVICES 63
ROUTINE PHYSICAL EXAMS 64
SKILLED NURSING FACILITY/INPATIENT REHABILITATION FACILITY 64
SPINAL MANIPULATION (CHIROPRACTOR) 65
SPINE AND JOINT SURGERIES 65
TELEHEALTH (TELEMEDICINE) 66
TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ) 66
TRANSPLANT SERVICES 67
TRAVEL AND LODGING 68
URINARY CATHETERS 68
URGENT CARE SERVICES 68
WELL-BABY/WELL-CHILD ROUTINE EXAMS 68
WIGS 69

X-RAY AND LAB SERVICES/X-RAY, RADIUM AND RADIOACTIVE ISOTOPE THERAPY 69

Plan Exclusions – What Is Not Covered 69

ALTERNATIVE TREATMENTS 69

AUTISM SPECTRUM DISORDER 69

COMFORT AND CONVENIENCE 70

DENTAL EXCLUSIONS 70

DRUGS 71

DURABLE MEDICAL EQUIPMENT (DME) 72

EXPERIMENTAL, INVESTIGATIONAL OR UNPROVEN SERVICES 72

FOOT CARE 72

GENDER DYSPHORIA 72

HABILITATIVE 72

MARIJUANA 72

MEDICAL SUPPLIES AND APPLIANCES 73

MENTAL HEALTH, NEUROBIOLOGICAL DISORDERS – AUTISM SPECTRUM DISORDER SERVICES AND SUBSTANCE-RELATED AND ADDICTIVE DISORDERS SERVICES 73

NUTRITION 73

PHYSICAL APPEARANCE 74

PRESCRIPTION DRUGS 74

PROVIDERS 76

REPRODUCTION 76

SERVICES PROVIDED UNDER ANOTHER PLAN 77

TRANSPLANTS 77

TRAVEL 77

VISION 77

ALL OTHER EXCLUSIONS 78

UnitedHealthcare Medical Plans - Claims Procedures 79

FILING A CLAIM 79

Required Information 79

Payment of Benefits 80

BENEFIT DETERMINATIONS 80

Post-Service Claims 80

Pre-Service Claims 80

Urgent Claims that Require Immediate Action 81

APPEALING A DENIED CLAIM 82

WHAT TO DO FIRST 82
HOW TO APPEAL A CLAIM DECISION 82
APPEAL PROCESS 83
APPEALS DETERMINATIONS 83
EXTERNAL REVIEW PROGRAM 85
YOUR FINAL RECOURSE – AFTER EXHAUSTION OF REMEDIES 87
Coordination of Benefits – UnitedHealthcare Medical Plans 87
BENEFITS WHEN YOU HAVE COVERAGE UNDER MORE THAN ONE PLAN 87
WHEN DOES COORDINATION OF BENEFITS APPLY? 87
WHAT ARE THE RULES FOR DETERMINING THE ORDER OF BENEFIT PAYMENTS? 88
HOW ARE BENEFITS PAID WHEN THIS PLAN IS SECONDARY? 89
HOW IS ALLOWABLE EXPENSE DETERMINED WHEN THIS PLAN IS SECONDARY 90
WHAT IS DIFFERENT WHEN YOU QUALIFY FOR MEDICARE? 90
RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION 90
DOES THIS PLAN HAVE THE RIGHT OF RECOVERY? 91
Definitions 91
ALTERNATE FACILITY 91
AIR AMBULANCE 92
ANCILLARY SERVICES 92
ANNUAL BENEFITS COMPENSATION 92
BALANCE BILLING 92
BRAND PRESCRIPTION 92
CALENDAR YEAR 92
CELLULAR THERAPY 93
CIVIL UNION 93
CLINICAL TRIAL 93
COINSURANCE 93
COMPOUND MEDICATION 93
CONGENITAL ANOMALY 93
COPAYMENT 93
COVERED HEALTH SERVICE(S) OR COVERED CHARGES 93
COVERED PERSON 94
CUSTODIAL CARE 94
DEDUCTIBLE 94
DEFINITIVE DRUG TESTING 94
DENTAL NECESSITY 94
DESIGNATED PROVIDER 94
DURABLE MEDICAL EQUIPMENT (DME) 95

ELIGIBLE EXPENSE 95
EMERGENCY 95
EMERGENCY ROOM 96
EMERGENCY HEALTH SERVICES 96
ESSENTIAL HEALTH BENEFITS 96
EXCLUSIONS (EXCLUDED SERVICES) 96
EXPERIMENTAL OR INVESTIGATIONAL SERVICES 96
FORMULARY AND NON-FORMULARY PRESCRIPTION DRUGS 97
FULL –TIME EMPLOYEE 97
GENERIC PRESCRIPTION 97
GENDER DYSPHORIA 97
GENE THERAPY 98
GENETIC COUNSELING 98
GENETIC TESTING 98
GESTATIONAL CARRIER 98
IATROGENIC INFERTILITY 98
IMMUNIZATION 98
INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT 98
INFERTILITY 98
INPATIENT 98
INTENSIVE BEHAVIORAL THERAPY (IBT) 99
INTENSIVE OUTPATIENT TREATMENT 99
MAINTENANCE MEDICATION 99
MAXIMUM LIFETIME BENEFIT 99
MEDICALLY NECESSARY 99
MENTAL HEALTH SERVICES 100
MENTAL ILLNESS 100
NETWORK PHARMACY 100
NETWORK PROVIDER 100
NEW PHARMACEUTICAL PRODUCT 100
NON-MEDICAL 24-HOUR WITHDRAWAL MANAGEMENT 100
NON-NETWORK PROVIDER 101
OUT-OF-NETWORK REIMBURSEMENT RATE 101
OUT-OF-POCKET MAXIMUM 101

OUTPATIENT 101
PALLIATIVE CARE 101
PART-TIME EMPLOYEE 101
PHARMACEUTICAL PRODUCT(S) 101
PHYSICIAN 101
PLAN 102
PLAN SPONSOR 102
PLAN YEAR 102
PREFERRED DRUG LIST (PDL) 102
PRESCRIPTION DRUGS 102
PRESUMPTIVE DRUG TEST 102
PREVENTIVE CARE 102
PRIOR AUTHORIZATION 102
PROVIDER 102
PRIVATE DUTY NURSING 103
REASONABLE AND CUSTOMARY (R&C) 103
RECOGNIZED AMOUNT 103
REMOTE PHYSIOLOGIC MONITORING 103
RESIDENTIAL TREATMENT FACILITY 104
SECRETARY 104
SKILLED NURSING 104
SPECIALIST 104
SPECIALTY MEDICATION 104
SUBSTANCE-RELATED AND ADDICTIVE DISORDERS SERVICES 104
SURROGATE 104
TELEHEALTH (TELEMEDICINE) 104
THERAPEUTIC DONOR INSEMINATION (TDI) 105
TOTAL DISABILITY 105
TRANSITIONAL LIVING 105
UNPROVEN SERVICES 105
URGENT CARE 106
UNITEDHEALTHCARE MEDICAL GUIDELINES 106
YOU / YOUR 106
Dental Plans **106**
DENTAL - PLAN CHOICES 106
DENTAL - NETWORK AND NON-NETWORK PROVIDERS 106
Metlife Network Provider (PDP Provider) 106
Find a MetLife PDP Provider 106

DENTAL - HOW THE PLAN WORKS 107
DENTAL – REASONABLE AND CUSTOMARY (R&C) 107
DENTAL - PRE-DETERMINATION BENEFITS 107
DENTAL - COVERED SERVICES 108
Preventive Services 108
Basic Services 108
Major Services 109
Orthodontic Services 109
How Orthodontia is Paid 109
REPLACEMENT RULE 109
DENTAL PLAN EXCLUSIONS - WHAT IS NOT COVERED 110
EXTENSION OF DENTAL BENEFITS 110
METLIFE DENTAL CLAIMS PROCEDURES 111
Filing a Dental Plan Claim 111
Urgent Care Claims Submission 111
METLIFE DENTAL – DENIED CLAIM APPEALS 111
How To Appeal A Metlife Dental Claim 112
DENTAL - COORDINATION OF BENEFITS 113
Dental – Determining Which Plan is Primary 114
VISION PLANS 114
VISION - PLAN CHOICES 114
VISION – HOW THE PLAN WORKS 114
ID Cards 115
How Benefits Eligibility is Determined 115
VISION - CLAIM PROCEDURES 115
VISION - PLAN EXCLUSIONS (WHAT IS NOT COVERED) 115
APPEALING A DENIED VSP CLAIM 116
Initial Determination 116
Request for Appeals 116
VISION - COORDINATION OF BENEFITS 117
VISION - DETERMINING WHICH PLAN IS PRIMARY 118
MEDICAL SECOND OPINION 118
HEALTH AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS (FSAs) 118
GENERAL AND LIMITED HEALTH CARE FSA 119

Tax Qualified Dependents 119
Section 152 Tax Dependent 119
IRS Qualifying Child 119
IRS Qualifying Relative 119
Tax Qualified Dependent 119
ANNUAL HEALTH CARE FSA ELECTION LIMIT 120
HEALTH CARE FSA - CARRYOVER PROVISION 120
HEALTH CARE FSA – ELIGIBLE EXPENSES 120
General Purpose Health Care FSA - Eligible Expenses 120
WHAT'S NOT ELIGIBLE 121
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT 121
Eligible Dependents 122
Covered Dependent Care Flexible Spending Account Expenses 122
What's Not Eligible 122
Your Dependent Care Flexible Spending Account Contributions 122
Health/Dependent Care FSA – Qualified Expenses & Reimbursement 123
FSA DEBIT MASTERCARD 123
Using Your FSA Debit MasterCard 124
USING YOUR FSA 125
Use It or Lose It (Dependent Care FSA) 125
Carryover Provision 125
FSA or Tax Deduction, Not Both 125
FSA or HSA, Not Both 126
General Purpose or Limited Purpose (Not Both) 126
Plan Year Elections 126
Open Enrollment 126
Increasing/Decreasing Elections 126
Claim Run-out Period 126
Monthly Health Statements and Yearly Statement 126
EFFECTIVE DATE AND COVERAGE PERIODS 126
WHEN COVERAGE ENDS 127
FLEXIBLE SPENDING ACCOUNT - AFFECT YOUR OTHER BENEFITS 128
FLEXIBLE SPENDING ACCOUNT (FSA) - CLAIM FILING 128
HEALTH CARE FSA – APPEAL PROCESS 129
DEPENDENT CARE FSA – APPEAL PROCESS 131
Group Term Life and Accidental Death and Dismemberment Insurance 132
GROUP TERM LIFE INSURANCE 132
Life Insurance – Pre-Tax Options 132

Life Insurance – After-Tax Options 132
Life Insurance – Minimum Required Coverage 132
GROUP ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE 133
AD&D- Pre-Tax Options 133
AD&D – Minimum Required Coverage 133
LIFE INSURANCE AND AD&D - COVERAGE CHANGES 133
LIFE INSURANCE AND AD&D - BENEFICIARY DESIGNATION 133
Long Term Disability Insurance 134
LONG TERM DISABILITY - PRE-TAX & AFTER-TAX OPTIONS 134
Long Term Disability – Three-Year Look Back 134
LONG TERM DISABILITY - MINIMUM REQUIRED COVERAGE 134
Medicare & ACME's Medical Plans 134
ELIGIBILITY 135
Medicare – Health Savings Accounts (HSAs) 135
Medicare – Coordination of Benefits 135
Kaiser Permanente HMO Plans 136
Other Important UnitedHealthcare Medical Plan Information 136
REVIEW AND DETERMINE BENEFITS IN ACCORDANCE WITH UNITEDHEALTHCARE REIMBURSEMENT POLICIES 136
RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION 137
PAYMENTS MADE 137
INCENTIVES TO YOU 137
REBATES AND OTHER PAYMENTS 137
RIGHT OF RECOVERY 137
IF YOU ARE INJURED THROUGH SOMEONE ELSE'S FAULT 137
SUBROGATION AND REIMBURSEMENT 138
RIGHT OF RECOVERY 140
PHYSICAL EXAMINATIONS 141
ASSIGNMENT OF BENEFITS PAYMENTS 141
REFUND OF OVERPAYMENTS 141
When Health Care Coverage Ends 143
COVERAGE IN THE EVENT OF AN EMPLOYEE DEATH 144
Disability Extensions Under UnitedHealthcare & HPHC Passport Plans 144
Disability Extensions Under HMO Medical Plans 144

Provisions For Employees Who Are Residents Of Hawaii **144**

COBRA Continuation Coverage Rights **145**

GENERAL 145

Continuation of Coverage Options 145

What Is COBRA Continuation Coverage? 146

Who Is Entitled to Elect COBRA? 146

When Is COBRA Coverage Available? 146

ELECTING COBRA 147

HOW LONG DOES COBRA LAST? 147

Disability extension of COBRA coverage 148

Second qualifying event extension of COBRA coverage 148

Medicare Extension for Spouse, Qualified Domestic Partner and Dependent Children 148

Health Care Flexible Spending Accounts (FSA) and COBRA 149

ADDITIONAL COBRA RIGHTS FOR TRADE-DISPLACED EMPLOYEES 151

COST OF COBRA COVERAGE 152

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT 152

Conversion To Individual Medical Coverage **152**

UNITEDHEALTHCARE: HSA MEDICAL PLAN, PPO, EPO , OR OUT-OF-AREA PLANS 152

KAISER PERMANENTE HMO 152

Legal and Administrative Information **153**

NAME AND ADDRESS OF EMPLOYER 153

ADMINISTRATIVE INFORMATION 153

AGENT FOR SERVICE OF LEGAL PROCESS 153

HIPAA Notice of Privacy Practices **157**

YOUR CHOICES 157

CONTACT US **161**

DIRECTORY OF PLANS AND ADMINISTRATORS **161**

EXECUTION **162**

Plan Document and Summary Plan Description (SPD)

This document constitutes the ACME America, Inc. Flexible Benefit Plan (“Plan”) written Plan document required by Section 402 of the Employee Retirement Income Security Act of 1974 (ERISA) and the Summary Plan Description (SPD) required by Section 102 of ERISA. It is also intended to satisfy the Section 125 of the Internal Revenue Code requirement for a written plan document.

Effective Date

The Plan has been amended since its original effective date and information contained in this document describes the Plan provisions in effect on January 1, 2024. This document updates and supplements all previous Plan documents and SPDs. To the extent that they are inconsistent, this document supersedes all communications.

Eligible Employees

An "Employee" shall mean a common law Employee of ACME America, Inc. (ACME)

FULL & PART TIME EMPLOYEES

You may participate in one of the medical, dental, vision, life/accidental death and dismemberment (AD&D), long term disability (LTD), and health care and dependent care flexible spending accounts (FSA) benefits offered under the Plan when You meet one of the eligibility requirements listed below.

- Regular Full-Time Employee on the ACME U.S. payroll scheduled to work 30 or more hours per week
- Regular Part-Time Employee on the ACME U.S. payroll scheduled to work 20-29 hours per week

Interns and temporary Employees are not eligible to participate in the Plan as they are not regular Employees of ACME. All Employees, Dependents, and other qualified members of the Employee's household are eligible for the Employee Assistance Program (EAP) at no cost.

If Your scheduled hours change and Your employment status changes from Full-Time to Part-Time status or from Part-Time to FullTime status, Your cost subsidy (if applicable) will be reduced. Your Annual Benefits Compensation will not be adjusted until January 1 of the next Plan Year.

Eligible Dependents

Your eligible Dependents may be covered by the medical, dental, vision, and life insurance options under the Plan when Your Dependent meets one of the eligibility requirements listed in this section. NOTE: Your Dependents may not enroll in a particular benefit option offered under the Plan unless You are also enrolled.

ELIGIBLE SPOUSE

- Your Spouse recognized under federal law (unless legally separated)

QUALIFIED DOMESTIC PARTNER

- Your Civil Union partner, which is defined as the individual with whom You entered into a valid Civil Union in a state that provides for Civil Unions; or
- Your same-sex or opposite-sex registered Qualified Domestic Partner as described under California Family Code section 297; or
- Your same-sex or opposite-sex Qualified Domestic Partner provided You meet all of the following requirements:
  - You are each other's sole Qualified Domestic Partners, are mutually responsible for Your common welfare and intend for this to remain so indefinitely; and
  - You share the same principal residence and are mutually responsible for Your financial obligations; and
  - You are both age 18 or older (or the age of consent in the state of Your residence) and mentally competent to consent to contract; and
  - You are not related by blood to a degree of closeness that would prohibit legal marriage in Your state of residence; and

- You (or Your Qualified Domestic Partner) are not legally married to another person.

The Plan allows coverage for same sex and opposite sex Qualified Domestic Partners. By enrolling Your Qualified Domestic Partner and his or her Children into the Plan – You also certify that all eligibility requirements (listed above) are met. For more information regarding coverage for a Qualified Domestic Partner – please view the information on the ACME US Benefits Website.

QUALIFIED DOMESTIC PARTNER – INCOME TAXES

Tax and Imputed Income

In accordance with the Internal Revenue Service (IRS), Your cost for Qualified Domestic Partner coverage is deducted on an after-tax basis. In addition, the amount ACME contributes towards the cost of Your Qualified Domestic Partner's coverage may be considered taxable income to You, resulting in additional income tax withholding. This additional tax is referred to as "Imputed Income" and is reflected on Your pay stub as "Other Compensation" on Your W-2. You are advised to consult with Your tax advisor.

Federal & State Tax Treatment

The ACME US Payroll System imposes the Federal Tax treatment of benefits for a Qualified Domestic Partner. Certain states do not tax employer-provided health coverage provided to a Civil Union partner or registered Qualified Domestic Partner. You should consult with Your tax advisor.

California Employees

Assembly Bill 25 (AB 25), which was effective January 1, 2002, provides the right to receive employer provided health coverage for a Qualified Domestic Partner without additional state income taxation. Application of this law is contingent upon registration of the Qualified Domestic Partnership with the State of California.

QUALIFIED DOMESTIC PARTNER – FEDERAL TAX DEPENDENT

If Your Qualified Domestic Partner[1] is a federal tax dependent, You are eligible to pay for Your Qualified Domestic Partner's coverage on a pre-tax basis and will not be subject to federal imputed income. In addition, if applicable, You may use Your General Purpose Health Care FSA, Limited Purpose Health Care FSA, and/or Health Savings Account (HSA) to pay for the qualified expenses of Your tax dependent Qualified Domestic Partner. You should consult with Your tax advisor if You have questions regarding whether Your Qualified Domestic Partner qualifies as Your Federal tax dependent for purposes of employer-provided health care.

ELIGIBLE CHILDREN

Your Child (and Your Qualified Domestic Partner's Child) are eligible for medical, dental, vision, and life coverage until he/she reaches the maximum allowable age.

- Your Child remains eligible for medical, dental and vision and life insurance coverage through the last day of the month of the
  Child's 26th birthday. For example, if Your Child turns 26 years old on December 3, he/she may continue coverage through December 31
- Your Child may continue coverage beyond age 26 if he or she is disabled. Refer to "Disabled Dependent Child" An eligible Child is Your and/or Your Spouse or Qualified Domestic Partner's:
- Son or Daughter
- Stepson or Stepdaughter Foster Child
  - Placed with You (and Your Spouse or Qualified Domestic Partner)
  - Placement must be made by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction
- Adopted Child
  - Includes a Child placed for adoption with You (and Your Spouse or Qualified Domestic Partner)

[1] See Internal Revenue Code Section 105(b).

- Child by Legal Guardianship
  - You (and Your Spouse or Qualified Domestic Partner) are appointed by a U.S. court as legal guardian; and
  - Child lives in the same residence as You (and Your Spouse or Qualified Domestic Partner); and
  - You (and Your Spouse or Domestic Partner) provide more than 50% of the Child's support for the Plan Year
- Disabled Dependent Child
  - Your unmarried Child is eligible for coverage beyond age 26 if the following requirements are met.
  - Your Child becomes permanently and totally disabled prior to age 26
  - Medical certification confirms Your Child is unable to engage in any substantial gainful activity by reason of a physical handicap or mental impairment
  - Your Child lives with You more than 50% the Plan Year
  - Your Child is not able to provide more than 50% of his or her own support
  - Coverage will continue as long as the enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Plan.
  - The Plan will ask you to furnish proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before the Plan agrees to this extension of coverage for the child, the Plan may require that a Physician chosen by the Plan examine the child. The Plan will pay for that examination.
  - The Plan may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at the Plan's expense. However, the Plan will not ask for this information more than once a year.
  - If you do not provide proof of the child's disability and dependency within 31 days of the Plan's request as described above, coverage for that child will end.
- Alternate Recipient of a Qualified Medical Child Support Order
  - Child is recognized by a QMCSO as an alternate recipient[2] having a right to coverage under the Plan
  - The Medical Child Support Order is "qualified" by meeting the legal requirements specified in Section 609 of the Employee Retirement Income Security Act of 1974
  - ACME will determine, in its sole discretion, whether a Medical Support Order is qualified

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a judgment or decree by a court of "competent jurisdiction" that requires a group health plan to provide coverage to a Plan participant's Child pursuant to a state domestic relations law.

If You are ordered by a court of law to provide health coverage for Your Child due to a Qualified Medical Child Support Order (QMCSO), judgment, or decree, the Plan's QMCSO Administrator may add the Child to your coverage, and You will be responsible to pay the appropriate cost. The effective date of coverage will be either the 1st or the 15th of the month, whichever occurs first after the QMCSO is determined to be qualified by the Plan's

[2] Any child(ren) of a participant in a group health plan who is recognized under a medical child support order as having a right to enrollment under the plan with respect to such participant is an alternate recipient.

QMCSO Administrator, unless otherwise required by the terms of the QMCSO. In addition, You may drop the child from your coverage if someone else is responsible for health coverage under a QMCSO. It is Your responsibility to notify ACME US Benefits and provide requested documentation following the date the QMCSO is issued.

The process to add a Child to health benefits is as follows:

- Only benefits, which are directly affected by the QMCSO, are allowed to be changed. To review which benefits are eligible to elect or alter as the result of a judgment or decree, review the list of Qualified Family Status Change events. The Plan's QMCSO Administrator will add the Child to the Medical, Dental and Vision plans as appropriate.
- The Plan's QMCSO Administrator will notify, in writing, You and the affected Child/custodial parent as to the date the coverage will start, the type of coverage elected, and how to contact ACME US Benefits if more information or assistance is required. This notice will be sent via first class mail to You and the custodial parent within 30 days of receiving notice of a QMCSO.

ACME's QMCSO Administrator
WTW Service Center
DEPT: QQP
PO Box 981924
El Paso, TX 79998
1-855-481-2661

ACME EMPLOYEES IN THE SAME FAMILY

If You, Your Spouse (or Qualified Domestic Partner), and adult Child are employed by ACME, each of You may be enrolled as an Employee OR be covered as a Dependent of the other person, but NOT both (except with respect to life insurance). In addition, if You and Your Spouse (or Qualified Domestic Partner), are both covered by the Plan, only one parent may enroll Your Child as a Dependent.

Examples:

Assume: John = employee & Jane's Spouse ~ Jane = employee & John's Spouse ~ Mary = employee & adult child of John and Jane

If…	Then…
John, Jane and Mary all elect "Employee only" coverage	They may not cover each other as a Dependent
John and his daughter Mary both "waive" coverage	Jane may cover both John and her daughter Mary as Dependent
Jane and her daughter Mary both "waive" coverage	John may cover both Jane and his daughter Mary as Dependents
John and Jane both elect coverage	One parent (John or Jane) may elect "Employee Only" coverage and the other parent (NOT BOTH) may cover their daughter Mar as a Dependent

RIGHT TO RESCIND COVERAGE

ACME reserves the right to request proof of Plan coverage eligibility and of a Qualified Family Status Change. Proof may include, but is not limited to, birth or marriage certificates, affidavit of Qualified Domestic Partnership, divorce, annulment, or adoption decrees.
Additionally, the Plan has the right to rescind coverage (i.e., discontinuance of coverage retroactively) for You and Your Dependents if You commit any acts of fraud or make an intentional misrepresentation of material fact when

applying for or obtaining coverage, or obtaining benefits under the Plan. The Plan also may seek financial damages caused by such acts of fraud or intentional misrepresentation of material fact and may pursue legal action against You. Such acts of fraud or intentional misrepresentation of material fact include, but are not limited to, adding a Dependent who is ineligible (e.g., adding a Spouse when You are not married, or adding a Child who does not meet the Plan's criteria of an eligible Dependent) or not dropping a Dependent who is no longer eligible (e.g., not dropping a Spouse when You divorce, or not dropping a Child who is no longer eligible).

Employee Cost To Participate

The actual cost to You to participate in the Plan will depend upon the benefits and coverage levels in which You have enrolled. Refer to the ACME US Benefits Enrollment System to view Your information including the costs for each benefit and coverage level, the credits You are provided by ACME, and the cost of Your specific benefit elections. Your cost and any applicable ACME subsidy "credits" are not pro-rated based on the number of days You are covered in a pay period.

ACME'S COST SUBSIDY "CREDITS" FOR LIFE/AD&D AND LONG TERM DISABILITY

ACME shares the overall cost of Your Life/AD&D and Long Term Disability benefits by way of per pay period[3] credits which reduces
Your total cost. All eligible Full-Time Employees scheduled to work 30 or more hours per week receive 100% of the subsidy. All eligible
Part-Time Employees scheduled to work 20 - 29 hours per week receive 50% of the subsidy. The subsidy amount is determined by Your age and Annual Benefits Compensation. You may view the cost and subsidy applicable to You on the ACME US Benefits Enrollment System.

ACME fully subsidizes Your Life/AD&D and Long Term Disability Insurance at the following coverage levels:

Life/AD&D

- Two Times Your Annual Benefits Compensation.
- Employees purchasing lower amounts of life insurance will receive a reduced credit amount as follows:
  - If You elect after tax-life insurance at 1x compensation, ACME will cover the cost of that election and You will also receive a $10 per pay period credit
  - If You elect only pre-tax life insurance of either $10k or $50k, You will receive a $20 per pay period credit
  - If You elect a combination of after-tax life insurance coverage at 1x compensation and pre-tax life insurance coverage of either $10,000 or $50,000, ACME will cover the cost of Your after-tax life insurance election plus You will receive a $10 per pay period credit

Long Term Disability

- 66 2/3 % of Your Annual Benefits Compensation

[3] ACME has 24 pay periods each year – Employees are paid on the 15th and the last day of each month.

Enrollment Information

To make Your benefit elections, access the ACME US Benefits Enrollment System and submit elections within 31 days of Your initial eligibility date (e.g., new hire date). If You do not enroll within 31 days, You may not make changes until the next annual Open Enrollment period or, if You experience a Qualified Family Status Change.

MINIMUM REQUIRED COVERAGE

The objective of the Plan is to provide You benefits that best suit the needs of Employees and family members. To ensure all Employees maintain a basic level of medical coverage and insurance protection, a minimum level of benefits is required of all ACME Employees. The minimum coverage required is listed below.

- Medical "Employee Only" Coverage
- Medical Plan coverage may be "Waived" if Employee is covered by an alternative medical plan such as a Spouse or Qualified Domestic Partner's employer's medical plan
- Employee pre-tax life insurance of $10,000 or employee after-tax life insurance of one-times Annual Benefits Compensation Employee AD&D Insurance of $10,000
- Long Term Disability Insurance at 50% of Annual Benefits Compensation

DEFAULT COVERAGE

If You are a newly eligible Employee (e.g., new hire) and do not complete Your enrollment during the designated enrollment period, You will automatically be enrolled in the default coverage listed below. Newly eligible Employees have 31 days following eligibility date (e.g., new hire date) to submit elections.

Default Coverage Includes:

- UnitedHealthcare HSA Medical Plan (Employee Only)
- Life Insurance: $10,000 Pre-Tax
- Accidental Death & Dismemberment (AD&D) Insurance: $10,000 Long Term Disability (LTD) Insurance: 50% Coverage Level

Default Coverage Does Not Include:

- Coverage for Your eligible Dependents (Spouse, Qualified Domestic Partner, and Children)
- Dental Insurance
- Vision Insurance
- Health/Dependent Care Flexible Spending Accounts (FSA)

Note: The Default Coverage does not provide coverage for Your eligible Dependents. Dependents are excluded from coverage and unable to enroll in the Plan until the earlier of:

- 62 days of a Qualified Family Status Change
- During the designated Annual Open Enrollment period

DECLINING OR "WAIVING" COVERAGE

Failure to make an election within the designated period will result in You receiving the default coverage and does NOT result in waived coverage. If You have alternate medical coverage (e.g., covered as a Dependent on Your Spouse or Qualified Domestic Partner's medical plan), and intend to waive ACME's medical coverage, You must actively waive coverage by accessing the ACME US Benefits Enrollment System and making an active "Waive" election.

When Coverage Begins

For newly eligible Employees, You must enroll Yourself and any eligible Dependents within 31 days of Your eligibility date (e.g., new hire date). If You fail to enroll within the 31-day period, You will be automatically enrolled in Default Coverage.

EFFECTIVE DATE OF CHANGE

- Employees: Your coverage will become effective on Your date of hire if You report to work and You are in an eligible class.
  For new hires through an acquisition, Your coverage will become effective on the date of Legal Entity Combination (LEC).
- Dependents: Provided You meet the enrollment deadline, coverage for Your eligible Dependents will go into effect on the date Your coverage goes into effect provided Your Dependents are in an eligible class, and Your Dependents are enrolled at the same time as You.

Pre-Existing Conditions

Certain benefits have imposed pre-existing conditions limitations.

Medical

There are no pre-existing condition limitations.

Dental

This benefit includes exclusions for treatment, surgery, services, or supplies performed on an area where the tooth (or teeth) was extracted prior to Your effective date of coverage. Refer to the Dental Replacement Rule, for more information on this exclusion.

Vision

There are no pre-existing condition limitations.

Long Term Disability

Long Term Disability Insurance imposes an exclusion for pre-existing conditions during the first 12 months of continuous coverage while actively at work. Should You receive any services, supplies, and/or prescriptions in the 90-day period prior to Your coverage effective date and during the first three months following Your coverage effective date, the condition will be considered pre-existing for the first 12 continuous months of being covered and actively at work. Medical leave is not included when calculating the 12 months of continuous coverage. Refer to the Certificate of Coverage for further information on pre-existing condition exclusions and other provisions.

Qualified Family Status Change (FSC) Changes

Your medical, dental, vision, flexible spending accounts, life/AD&D, and long term disability election(s) will remain in effect for the entire Plan Year, or the remainder of the Plan Year if You were hired after the first day of the Plan Year. You may only make changes to Your elections during the Annual Open Enrollment period or when You have a Qualified Family Status Change as defined by the Internal Revenue Service (IRS).

Certain insurance policies, such as Life/AD&D and Long Term Disability may prevent changes to the policies mid-year even when the change would be otherwise allowed under this Plan. You should consult the specific descriptions, certificates of insurance and the policies themselves for these restrictions. Information is available on the ACME US Benefits Website.

Detailed information regarding governance, reporting events, and deadlines are available on the ACME US Benefits Website. A list of current Qualified Family Status Changes are outlined in the Qualified Family Status Change document. If You have questions about allowable changes following a Qualified Family Status Change, contact ACME US Benefits.

Note: ACME reserves the right to request proof of Your Qualified Family Status Change. Proof may include, but is not limited to, birth or marriage certificates, affidavit of Qualified Domestic Partnership, divorce, annulment, or adoption decrees.

CONSISTENCY RULE

Making changes to Your benefits elections because of a Qualified Family Status Change are permissible when the event (e.g., marriage, divorce, birth of baby) affects Your or Your Dependents' benefits eligibility. Furthermore, benefit changes made must directly correlate with the event. For example, if You divorce, You must drop Your former Spouse from coverage, but You may not drop Your Children's coverage.

EFFECTIVE DATE OF BENEFIT CHANGES

Elections made because of a Qualified Family Status Change must be submitted within 62 days of the qualifying event date. If You fail to report and/or submit Your benefit changes within the 62-day period, You will have to wait until the next Open Enrollment or another Qualified Family Status Change to make benefit changes. Keep in mind, the Qualified Family Status Change date and the effective date of the benefit changes You submit may not be the same. Provided You submit Your benefit elections within 62 days of Your Qualified Family Status Change, Your benefit changes are effective on either:

- the date of Your Qualified Family Status Change; or
- the date Your election is submitted

You are unable to submit Qualified Family Status Change prior to the date of the event (e.g., marriage). In these cases, You may contact ACME US Benefits to submit Your notice prior to the event. A list of current Qualified Family Status Changes and the effective date of Your changes are found in the Qualified Family Status Change document.

LIST OF QUALIFIED FAMILY STATUS CHANGES

A list of Qualified Family Status Changes in which You may make a mid-year election are outlined in the Qualified Family Status Change document, which is incorporated herein by reference and is a part of this Plan document and Summary Plan Description. **IMPORTANT NOTE:** ACME reserves the right to request proof of Your Qualified Family Status Change. Proof may include, but is not limited to, birth or marriage certificates, affidavit of Qualified Domestic Partnership, divorce, annulment, or adoption decrees.

SPECIAL ENROLLMENT CIRCUMSTANCES

You or Your eligible Dependent may enroll in the Plan's medical coverage if You or Your eligible Dependent, as applicable:

- Lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP); or
- become eligible for premium assistance for medical coverage provided through the Plan pursuant to Medicaid or CHIP

NEWBORN AND OTHER NEWLY ACQUIRED CHILDREN

If You give birth, Your newborn eligible Child(ren) as defined in the Eligibility section of this document are automatically covered for the first 31 days on the UnitedHealthcare Medical Plan in which You are enrolled. If You want coverage to extend beyond the first 31 days, You must submit a Qualified Family Status Change and make an

election to enroll Your eligible Child(ren). Children are not covered beyond the initial 31-day period unless You add Your eligible Child(ren) within 6 months (62 days for Kaiser Permanente HMO medical option) of birth.

REPORTING A QUALIFIED FAMILY STATUS CHANGE

Access the ACME US Benefits Enrollment System to make Your changes. If You do not make Your changes within 62 days of the event, You must wait until the next annual Open Enrollment period to make any changes. The ACME US Benefits Enrollment System will only allow You to make changes to eligible benefits following the consistency rules that apply to Your specific Qualified Family Status Change.

IMPORTANT NOTE: Review Your ability to add family members to UnitedHealthcare medical (**this does not apply to the Kaiser HMO plans**), dental, and vision plans in certain circumstances without a Qualified Family Status Change. As permitted under IRS rules, because the following changes to Your benefit elections will not result in a change in Your pre-tax payroll deduction, You may make the following changes during the Plan Year without experiencing a Qualified Family Status Change:

- UnitedHealthcare Medical Plans - If You elected coverage for at least one Child, You may add additional Children to Your medical coverage (**this does not apply to the Kaiser HMO plans**)
- Dental Plan I – You can elect coverage and/or add Your Spouse, tax dependent Qualified Domestic Partner or Child(ren) to Your dental coverage
- Dental Plan II - If You elected coverage for at least one Child, You may add additional Children to Your dental coverage
- Vision Plans - If You elected coverage for any of Your eligible Dependents, You may add Your Spouse, tax dependent
  Qualified Domestic Partner or Child(ren) to Your vision coverage

To add family members, You must contact ACME US Benefits at benefits_us@ACME.com. These changes may NOT be made through the ACME US Benefits Enrollment System. The addition of Your family member(s) will be effective on a prospective basis (i.e., the date You notify ACME US Benefits).

Open Enrollment

Each year You are given the opportunity to enroll for the first time, if eligible, change Your elections or enroll previously eligible Dependents that were not covered under the Plan. Any changes You make during Open Enrollment will go into effect on January 1.

You may not change Your election (or deemed election) after Open Enrollment ends, even if it is prior to January 1, unless You have a Qualified Family Status Change. These changes will remain in effect for the entire Calendar Year unless You have a Qualified Family Status Change and make any changes within **62** days of the event date.

If You do not make any changes to Your existing elections during Open Enrollment, You and Your eligible enrolled Dependents will automatically be re-enrolled in the same benefits and coverage levels (with the exception of Health Savings Account contribution amounts[4]) for the next Calendar Year, including Flexible Spending Accounts.

Medical Plans

This section outlines the key features and provisions of the ACME UnitedHealthcare Medical Plans and regional Kaiser Permanente HMO Medical Plans. For more information about medical coverage, refer to the Medical Plan

[4] If You are a participant in the UnitedHealthcare HSA Medical Plan and want to contribute to Your HSA for the following Year, You must make a new election during Open Enrollment.

Comparison Chart, which is incorporated herein by reference and is a part of this Plan document and Summary Plan Description.

Medical Plans Offered

You have the choice of the following medical options:

- UnitedHealthcare HSA Medical Plan
- UnitedHealthcare Medium PPO Plan
- UnitedHealthcare Premium PPO Plan
- UnitedHealthcare Exclusive Provider Organization (EPO) Plan
- UnitedHealthcare's Harvard Pilgrim Passport Plan
- UnitedHealthcare's Exclusive Provider Organization (EPO) Plan – Hawaii
- UnitedHealthcare Medium and Premium Out-of-Area Plans[5]
- Kaiser Permanente HMO Plans (CA, CO, OR, WA, Mid-Atlantic, Atlanta)

MEDICAL PLANS - SERVICE AREAS

Your home zip code determines the medical plan service area that You live in – and the medical plan(s) You may enroll in. Most of the medical plans are available nationwide, however, certain medical plans are only available in certain geographic areas. The medical plans available in certain regions of the country are - Kaiser Permanente HMO and the UnitedHealthcare Harvard Pilgrim Passport Plan.

If Your eligible Dependent(s) do not live with You, You may still choose a medical plan for both You and Your eligible Dependent(s).
The amount of covered expenses that are paid will be based on whether You and Your eligible Dependent(s) received Covered Health
Services from a Network Provider or Non-Network Provider. For the UnitedHealthcare Plans, most Employees will access the
Physicians and facilities in the UnitedHealthcare Choice or Choice Plus Network (California employees will access the
UnitedHealthcare Select or Select Plus Network). To check which medical plans You may enroll in, access the online Medical Plan Options Tool.

UnitedHealthcare Medical Plans

The information contained in this section "UnitedHealthcare Plans" applies to all of the UnitedHealthcare Plans.

PROVIDER NETWORKS

You may access the online Provider Network directory at www.myuhc.com. The Network status of a Physician or facility may change during the year. It is Your responsibility to check the UnitedHealthcare online provider directory frequently to verify the Network status of Your Provider.

Network Providers

UnitedHealthcare or its affiliates arrange for health care Providers to participate in a Network. At Your request, UnitedHealthcare will send You a directory of Network Providers free of charge. Keep in mind, a Provider's Network status may change. To verify a Provider's status or request a Provider directory, You can call UnitedHealthcare at the number on Your ID card or log onto **www.myuhc.com**.

[5] If You do not live in the service area of any of the medical plans, You will be eligible for the UnitedHealthcare Out-of-Area Plans.

Network Providers are independent practitioners and are not employees of any ACME Entity or UnitedHealthcare.

UnitedHealthcare credentialing process confirms public information about the Providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services, You should always verify the Network status of a Provider. A Provider's status may change. You can verify the Provider's status by calling UnitedHealthcare. A directory of Providers is available online at **www.myuhc.com** or by calling the telephone number on Your ID card to request a copy. If You receive a Covered Health Service from a Non-Network Provider and were informed incorrectly prior to receipt of the Covered Health Service that the Provider was a Network Provider, either through a database, provider directory, or in a response to Your request for such information (via telephone, electronic, web-based or internetbased means), You may be eligible for Network Benefits.

It is possible that You might not be able to obtain services from a particular Network Provider. The Network of Providers is subject to change. Or You might find that a particular Network Provider may not be accepting new patients. If a Provider leaves the Network or is otherwise not available to You, You must choose another Network Provider to get Network Benefits. However, if You are currently receiving treatment for Covered Health Services from a Provider whose network status changes from Network to Non-Network during such treatment due to expiration or nonrenewal of the Provider's contract, You may be eligible to request continued care from Your current Provider at the Network Benefit level for specified conditions and timeframes. This provision does not apply to Provider contract terminations for failure to meet applicable quality standards or for fraud. If You would like help to find out if You are eligible for continuity of care Benefits, please call the telephone number on Your ID card.

If You are currently undergoing a course of treatment utilizing a Non-Network Physician or health care facility, You may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If You have questions regarding this transition of care reimbursement policy or would like help determining whether You are eligible for transition of care Benefits, please contact UnitedHealthcare at the telephone number on Your ID card.

Do not assume that a Network Provider's agreement includes all Covered Health Services. Some Network Providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network Providers choose to be a Network Provider for only some of UnitedHealthcare's products. Refer to your Provider directory or contact UnitedHealthcare for assistance.

Provider Network Names

The online directory contains a list of Provider Network names. The table below provides a list of the ACME UnitedHealthcare Plans and the corresponding UnitedHealthcare Network names.

UnitedHealthcare Medical Plans	UnitedHealthcare Network Directly Equivalent (outside California)	UnitedHealthcare Network Directly Equivalent (in California)
Medium PPO	UnitedHealthcare Choice Plus	UnitedHealthcare Select Plus
Premium PPO	UnitedHealthcare Choice Plus	UnitedHealthcare Select Plus
HSA Medical Plan	UnitedHealthcare Choice Plus	UnitedHealthcare Select Plus
EPO Plan	UnitedHealthcare Choice	UnitedHealthcare Select
HPHC (Harvard Pilgrim)	Harvard Pilgrim Choice	N/A

Services Without a Viable Provider Network

Certain Covered Health Services (see below) do not have a viable Provider Network in many areas of the United States. For these Covered Health Services ONLY, the UnitedHealthcare Medical Plans (including Harvard Pilgrim HPHC) provide a higher Non-Network benefit when compared to other Non-Network Covered Health Services. This provision is applicable to the services listed below. Standard Network benefits are paid should You receive services from a Network Provider. The standard Non-Network benefits apply to all Covered Health Services, except for those that qualify for higher benefits.

Higher Non-Network benefits apply to these Covered Health Services:

- Acupuncture
- Applied Behavior Analysis (ABA)
- Hearing Aids
- Emergency Services
- Fertility Services

Refer to "Covered Health Services" and the Medical Plan Comparison Chart.

Eligible Expenses

ACME has delegated to UnitedHealthcare the initial discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that the Plan will pay for Benefits.

- For Designated Network Benefits and Network Benefits for Covered Health Services provided by a Network Provider, except for Your cost sharing obligations, You are not responsible for any difference between Eligible Expense and the amount the Provider bills.
- For Non-Network Benefits, except as described below, You are responsible for paying, directly to the Non-Network Provider, any difference between the amount the Provider bills You and the amount UnitedHealthcare will pay for Eligible Expenses.
  - For Covered Health Services that are Ancillary Services received at certain Network facilities on a non-Emergency basis from Non-Network Physicians, You are not responsible, and the Non-Network Provider may not bill You, for amounts in excess of Your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.
  - For Covered Health Services that are non-Ancillary Services received at certain Network facilities on a non-Emergency basis from Non-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below, You are not responsible, and the Non-Network Provider may not bill You, for amounts in excess of Your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.
  - For Covered Health Services that are Emergency Health Services provided by a Non-Network Provider, You are not responsible, and the Non-Network Provider may not bill You, for amounts in excess of Your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.
  - For Covered Health Services that are Air Ambulance services provided by a Non-Network Provider, You are not responsible, and the Non-Network Provider may not bill You, for amounts in excess of Your applicable Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network Provider. which is based on the Recognized Amount as defined in the SPD.

Eligible Expenses are determined in accordance with UnitedHealthcare's reimbursement policy guidelines or as required by law, as described in the SPD.

Designated Network Benefits and Network Benefits
Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Network and Network Provider, Eligible Expenses are the contracted fee(s) with that Provider.
- When Covered Health Services are received from a Non-Network Provider as arranged by UnitedHealthcare, including when there is no Network Provider who is reasonably accessible or available to provide Covered Health Services, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if You are billed for amounts in excess of Your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts You are not legally obligated to pay.

Non-Network Benefits
When Covered Health Services are received from a Non-Network Provider as described below, Eligible Expenses are determined as follows:

- For non-Emergency Covered Health Services received at certain Network facilities from Non-Network Physicians **when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Health Service Act with respect to a visit as defined by the Secretary (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen urgent medical needs arise at the time the services are provided), the Eligible Expense is based on one of the following in the order listed below as applicable**:
  - The reimbursement rate as determined by a state All Payer Model Agreement. ○ The reimbursement rate as determined by state law.
  - The initial payment made by UnitedHealthcare, or the amount subsequently agreed to by the Non-Network Provider and UnitedHealthcare.
  - The amount determined by Independent Dispute Resolution (IDR).

  For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the Social
  Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

  IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, You are not responsible, and a Non-Network Physician may not bill You, for amounts in excess of Your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- **For Emergency Health Services provided by a Non-Network Provider**, the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.

- The reimbursement rate as determined by state law.
- The initial payment made by UnitedHealthcare, or the amount subsequently agreed to by the Non-Network Provider and UnitedHealthcare.
- The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and a Non-Network Provider may not bill You, for amounts in excess of Your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- For Air Ambulance transportation provided by a Non-Network Provider**, the Eligible Expense is based on one of the following in the order listed below as applicable**:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by UnitedHealthcare, or the amount subsequently agreed to by the Non-Network Provider and UnitedHealthcare.
  - The amount determined by Independent Dispute Resolution (IDR).

  IMPORTANT NOTICE: You are not responsible, and a Non-Network Provider may not bill You, for amounts in excess of Your Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network Provider which is based on the Recognized Amount as defined in the SPD.

- **For Emergency ground ambulance transportation provided by a Non-Network Provider**, the Eligible Expense, which includes mileage, is a rate agreed upon by the Non-Network Provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network Providers for the same or similar service.

  IMPORTANT NOTICE: Non-Network Providers may bill you for any difference between the Provider's billed charges and the Eligible Expense described here.

- **When Covered Health Services are received from a Non-Network Provider, except as described above, Eligible Expense are determined as follows:** (i) an amount negotiated by UnitedHealthcare, (ii) a specific amount required by law (when required by law), or (iii) an amount UnitedHealthcare has determined is typically accepted by a healthcare Provider for the same or similar service or an amount that is greater than such rate when elected or directed by the Plan. The Plan will not pay excessive charges. You are responsible for paying, directly to the Non-Network Provider, the applicable Coinsurance, Copayment or any deductible. Please contact UnitedHealthcare if You are billed for amounts in excess of Your applicable Coinsurance, Copayment or any deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Eligible Expense (which includes your Coinsurance, Copayment, and deductible) is Yours.

Advocacy Services

The Plan has contracted with UnitedHealthcare to provide advocacy services on Your behalf with respect to Non-Network Providers that have questions about the Eligible Expenses and how UnitedHealthcare determined those amounts. Please call UnitedHealthcare at the number on Your ID card to access these advocacy services, or if You are billed for amounts in excess of Your applicable Coinsurance or Copayment. In addition, if UnitedHealthcare, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Eligible Expense, and UnitedHealthcare, or its designee, determines that it would serve the best interests of the Plan and its Employees

(including interests in avoiding costs and expenses of disputes over payment of claims), UnitedHealthcare, or its designee, may use its sole discretion to increase the Eligible Expense for that particular claim.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network Provider, You may be eligible to receive Network Benefits when
Covered Health Services are received from a Non-Network Provider. In this situation, Your Network Provider will notify
UnitedHealthcare, and if UnitedHealthcare confirms that care is not available from a Network Provider, UnitedHealthcare will work with You and Your Network Provider to coordinate care through a Non-Network Provider.

Network Provider Termination

In the event a Covered Person is receiving care from a Network Provider (for one of the conditions listed below) and the Network Provider terminates his or her contract with UnitedHealthcare, continuation of care with the terminated Provider may be arranged up to certain time periods identified below.

- An acute condition or serious chronic condition ○ Treatment by the Terminated Provider may continue up to 90 days
- A high-risk pregnancy (or second or third trimester pregnancy) ○ Treatment by the Terminated Provider may continue until the postpartum services related to the delivery are completed

Treatment by the Terminated Provider for the medical conditions above may continue for a longer period than shown above if it is necessary for a safe transfer to another Provider, as determined by consultation with the Provider and authorized by UnitedHealthcare.

Out-of-Pocket costs are usually higher than a Network Provider.

UnitedHealthcare - HSA Medical Plan

The HSA Medical Plan is an IRS-qualified high deductible health plan. If You participate in the HSA Medical Plan, You may choose to contribute to a Health Savings Account (“HSA”) on a pre-tax basis under the Plan. The HSA Medical Plan has a higher Plan Deductible and a higher Out-of-Pocket Maximum when compared to ACME’s other medical plan offerings; however, it provides a lower per pay period cost than the other plans. This plan provides coverage for services You receive from Network and Non-Network Providers.

High Deductible Health Plan (HDHP)

Eligible Preventive Care Services and Preventive Prescription Drugs are covered at 100% (of R&C for Non-Network Providers) and are not subject to a Plan Copayment, Deductible, or Coinsurance. All other services, including non-Preventive Prescription Drugs, are subject to the Plan Deductible and Coinsurance. The HSA Medical Plan requires You to pay 100% of Covered Health Services until You meet the Plan Deductible. You may use any licensed Physician or licensed health care facility, but the Plan covers a greater percentage of cost when You use a Network Provider. Other than the exceptions listed below, when a Covered Person receives care from a Network Provider, the Plan pays 90% of the Network contract charges after the Plan Deductible is met. When a Covered Person receives care from a Non-Network Provider, the Plan pays 70% of Reasonable and Customary (R&C) charges after the Plan Deductible is met.

The HSA Medical Plan provides a higher level of Non-Network coverage for services that do not have a viable Provider Network. Refer to "Services Without a Viable Provider Network"

The Plan's Out-of-Pocket Maximum is the most You will be required to pay each Plan Year. Once the Plan Out-of-Pocket Maximum is met, covered Network eligible expenses are paid at 100% and covered Non-Network eligible expenses are paid at 100% of **Reasonable and Customary (R&C). Aside from the exceptions noted above, coverage for care You receive from a Non-Network Provider is limited to R&C charges. You will be responsible for all amounts the Non-Network Provider charges above the R&C charges.**

For more information about Plan coverage, refer to Medical Plan Comparison Chart.

Health Savings Account (HSA)

A Health Savings Account (HSA) is a tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in an IRS-qualified high deductible health plan (HDHP). The funds contributed to the HSA are not subject to federal income tax at the time of deposit. The money saved in the account can be used now or in the future to pay for qualified medical, dental and vision care expenses. HSA benefits under this Plan consist solely of the ability to make contributions to the HSA on a pre-tax basis. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, etc.) will be provided by and are set forth in the HSA, not this Plan. The HSA is not an ACME-sponsored ERISA employee benefits plan. It is a savings account that is established and maintained by Optum Bank outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Internal Revenue Code Section 223(d)(2). ACME has no authority or control over the funds deposited in an HSA.

ACMEs HSA Contribution (Seed)

When You enroll in the HSA Medical Plan for the first time, You will need to establish a personal account in Your name with ACME's Health Savings Account administrator, Optum Bank. This is will be accomplished once you have completed the eligibility affirmation in the ACME US Benefits Enrollment system. Once You have opened Your HSA and Your new hire enrollment window closes (i.e., 31 days following Your new hire date), ACME will contribute to Your HSA. If you do not open your account by December 31 by completing the eligibility affirmation in the ACME US Benefits Enrollment system, your ACME HSA contribution for the year will be forfeited. The amount You receive is based upon Your medical plan coverage tier (e.g., "Employee Only", "Family") and Your Annual Benefits Compensation. Mid-year enrollees receive a pro-rated contribution based on Your Plan entry date. In addition, an increase to Your coverage tier (e.g., Change from "Employee Only" to "Employee + Children"), following a Qualified Family Status Change, will result in an additional pro-rated contribution.. All ACME contributions are 100% vested.

If You first participate in the HSA Medical Plan on November 15 or later, You will not receive an ACME HSA contribution for that year.
Thereafter, at the beginning of each Plan Year, ACME will contribute to Your HSA so long as you are enrolled in the HSA Medical Plan.

For more information about ACME's HSA contributions, please refer to the HSA Medical Plan Resource Center.

HSA Personal Contributions

In addition to ACME's contribution to Your HSA, You may personally contribute to Your HSA on a pre-tax basis up to annual IRS limits. For more information about HSA contributions, please refer to the HSA Medical Plan Resource Center. It is also recommended that You always seek advice from a qualified tax professional regarding the tax implications of HSAs.
You may contribute up to the IRS statutory maximum less ACME's annual HSA contribution amount. The IRS determines the annual HSA contribution maximums each year. For 2024, the IRS statutory maximum is $4,150 ($5,150 if eligible for catch-up) for individual coverage and $8,300 ($9,300 if eligible for catch-up) for family coverage (individual + 1 Dependent). You may prospectively change Your HSA at any time during the Plan Year.

Changes to Your election will generally appear on the first pay period of the month following Your election. However, You may not make a new HSA election or change Your HSA election on or after November 15 of any year. For more information regarding HSAs, please review the HSA Medical Plan Resource Center. It is also recommended that You always seek advice from a qualified tax professional regarding the tax implications of HSAs.

UnitedHealthcare - PPO Medical Plans

The UnitedHealthcare Medium and Premium PPO Plans have lower Plan Deductibles and Out-of-Pocket Maximums when compared to the HSA Medical Plan. The Premium and Medium PPO Medical Plans are not IRS-qualified high deductible health plans and do not offer a Health Savings Account (HSA). While You will pay a lower Plan Deductible and Out-of-Pocket Maximum, these plans have a higher per pay period cost than the HSA Medical Plan.

Eligible Network Preventive Care Services are covered at 100%. Network Preventive Care Services are not subject to the Plan
Copayment, Deductible, or Coinsurance. All other services are subject to the applicable Plan Copayment, Deductible, and Coinsurance. Certain Preventive medications and supplies are also covered at 100% (as required by the Affordable Care Act). However, the HSA Medical Plan covers an expanded list of zero cost Preventive Prescription Drugs.

The Premium and Medium PPO Plans offer benefits for Covered Health Services received by Network and Non-Network Providers. You may access care from any licensed Physician or health care facility; however, both plans cover a greater portion of Eligible Expenses when Network Providers are used – which may result in lower Out-of-Pocket costs for You.

These Plans have a higher level of Non-Network coverage for services that do not have a viable Provider Network. Refer to "Services Without a Viable Provider Network"
For more information about medical coverage, refer to Medical Plan Comparison Chart.

UHC Premium PPO Plan

The Premium PPO Plan provides high-level Network and Non-Network benefits coverage, low Deductibles and Out-of-Pocket Maximums, and the per pay period cost is the most expensive when compared to the other medical plans. When Network Providers are used, General Physician and Specialist office visits are covered at 100% and requires a “per visit” Copayment. For most other Covered Health Services, the Plan pays 100% of the Network Provider’s discounted contract rate (after Deductible) and 80% of NonNetwork R&C charges (after Deductible). Refer to the Medical Plan Comparison Chart to view coverage details.

UHC Medium PPO Plan

The Medium PPO Plan provides mid-level Network and Non-Network benefits coverage, medium Deductibles and Out-of-Pocket Maximums, and the per pay period cost is modest. When Network Providers are used, General Physician and Specialist office visits are covered at 100% and requires a “per visit” Copayment. For most other Covered Health Services, the
Contributions[6] to a health savings account (HSA) are exempt from federal tax and in most cases are exempt from state tax as well. Please consult Your tax/financial professional or consult Your state department of revenue for more information.

[6] Contributions to a health savings account (HSA) are exempt from federal tax and in most cases are exempt from state tax as well. Please consult Your tax/financial professional or consult Your state department of revenue for more information.

Plan pays 90% of the Network Provider's discounted contract rate (after Deductible) and, 70% of Non-Network R&C charges (after Deductible). Refer to the Medical Plan Comparison Chart to view coverage details.

UnitedHealthcare – EPO Medical Plan

The EPO Plan provides high-level Network only benefits coverage, low Deductibles and Out-of-Pocket Maximums, and the per pay period cost is one of the least expensive when compared to the other medical plans. The UnitedHealthcare Exclusive Provider Organization (EPO) Plan is similar to an HMO, because other than a few exceptions (below), You are required to receive care from Network Providers. The EPO Plan does not require You to select a primary care physician or obtain a written "referral" to see a Specialist.

The EPO Plan will cover Non-Network services that do not have a viable Provider Network. Refer to "Services Without a Viable Provider Network."

Eligible Network Preventive Care Services are fully covered and free of charge. Certain Preventive medications and supplies are covered at no charge (as required by the Affordable Care Act). However, the Preventive Prescription Drug coverage offered in the HSA Medical Plan is not offered in the EPO Plan. All other services are subject to the applicable Plan Copayment, Deductible, and Coinsurance. The EPO Plan covers Network Physician and Specialist office visits at 100% and requires a "Per Visit" Copayment. It is especially important to verify the Network status of Your Providers in this Plan. The majority of services are not covered if a NonNetwork Provider is used.

Refer to the Medical Plan Comparison Chart to view coverage details.

UnitedHealthcare - Harvard Pilgrim Passport Medical Plan

UnitedHealthcare's Harvard Pilgrim Passport Plan (HPHC) requires You to use Network Providers and is available to most Employees who live in Massachusetts, Maine, New Hampshire, and the cities in Vermont and New York that border Massachusetts or New Hampshire. Although UnitedHealthcare administers the Plan, You will have access to Harvard Pilgrim Providers.

You may enroll in this Plan if You live in the Harvard Pilgrim service area. If Your eligible covered Dependent does not live with You,

You may still choose the HPHC-Passport Plan. Harvard Pilgrim covers most Covered Health Services at 100% after You pay a Deductible or Copayment per visit (excluding Preventive Care, which is covered at 100%). There are no claim forms to file. You must use only HPHC doctors and facilities when You are in the HPHC Service Area. You are not required to choose a PCP or obtain written authorization or referrals to Specialists.

This Plan covers Non-Network services that do not have a viable Provider Network. Refer to "Services Without a Viable Provider Network."

You and Your covered Dependents have access to the UnitedHealthcare Choice Network when You are outside the HPHC Service Area. This includes eligible Dependents that may live outside of the Harvard Pilgrim service area (e.g., college students). You must use Harvard Pilgrim or UnitedHealthcare Choice Network doctors and facilities to receive benefits, except in an Emergency.

Refer to the Medical Plan Comparison Chart to view coverage details.

UnitedHealthcare - Out of Area Medical Plans

If You live outside the UnitedHealthcare PPO or service areas, You may enroll in the Medium or Premium Out-of-Area Plans. The primary differences between the Medium and Premium Out-of-Area Plans are the Deductible and Out-of-Pocket Maximum amounts. The Out-of-Area Plan is designed to cover most Covered Health Services at 80% of billed charges after the Plan Deductible is met.

Eligible Preventive Care services are covered at 100% of billed charges. Due the extensive reach of the OptumRx Pharmacy Network

(and Mail Order Services), Prescription Drug benefits are not modified in this Plan. Plan benefits are the same as the Medium and Premium PPO Plans. Refer to the Medical Plan Comparison Chart to view coverage details.

Out-of-Area Plan Override

You may opt-out of the UnitedHealthcare Medium and Premium Out-of-Area Plans and choose to enroll in another Plan if You have reasonable access to Network Providers and/or You have an enrolled Dependent who lives within the UnitedHealthcare Choice Plus or Choice service area (or the UnitedHealthcare Select Plus or Select service area in California). To initiate an override, please contact ACME US Benefits.

UnitedHealthcare Medical Plans - Prior Authorization

IMPORTANT: Certain Covered Health Services are subject to Prior Authorization review. If a Covered Person does not obtain Prior Authorization, before receiving any of the Covered Health Services Requiring Prior Authorization, benefits may:

- be reduced if UnitedHealthcare determines the admission or service is a Covered Health Service; or
- no benefits will be payable if UnitedHealthcare determines the admission or service is not a Covered Health Service

Prior Authorization – Who is Responsible?

Prior Authorization requirements are the responsibility of the Network Provider or Covered Person – see below.

- Network Providers are responsible for obtaining Prior Authorization
- Non-Network Providers are NOT responsible for obtaining Prior Authorization – You, the Covered Person is responsible
- To initiate Prior Authorization, contact UnitedHealthcare by calling the toll-free number located on the back of Your ID card

Covered Health Services Requiring Prior Authorization

The Covered Health Services listed below (in alphabetical order) require Prior Authorization. Failure to obtain Prior Authorization on required Covered Health Services will result in a reduction of benefits or no benefits paid. A $200 penalty is imposed if there is no prior authorization for Non-Network services with the exception of Non-Network Outpatient Mental Health and Substance Abuse. The penalty does not apply towards Plan Deductible or Out-of-Pocket Maximum.

- Ambulance (Non-Emergency Transportation)
- Applied Behavioral Analysis (ABA)
- Bariatric (Obesity) Surgery
- Cardiology ○ Cardiac Catheterization ○ Pacemaker Insertion
    - ○ Implantable Cardioverter Defibrillators ○ Electrophysiology Implants
- Cellular and Gene Therapy (In-Network only, Non-Network not covered)
- Clinical Trials
- Congenital Heart Disease Surgery
- Durable Medical Equipment (For items that will cost more than $1,000 to purchase or rent – including diabetes equipment)

- Gender Dysphoria
- Gynecomastia
- Home Health Care, including Private Duty Nurse and nutritional foods
- Hospice Care (Inpatient)
- Hospital (Inpatient)
  - All scheduled non-maternity admissions and maternity admissions exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery
- Fertility Services
- Laboratory and X-Ray Related to Genetic Testing
- Major Diagnostics (e.g., CT, PET Scans, MRI, MRA) – including sleep studies and Nuclear Medicine (Including Diagnostic Catheterization)
- Mental Health Services, Neurobiological Disorders – Autism Spectrum Disorder Services, Substance-Related and Addictive Disorders Services ○ Inpatient Services ○ Partial Hospitalization and Day Treatment ○ Services at a Residential Treatment Facility ○ Intensive Outpatient Treatment Program ○ Outpatient Electro-Convulsive Treatment ○ Psychological Testing ○ Transcranial Magnetic Stimulation ○ Intensive Behavioral Therapy, Including Applied Behavior Analysis (ABA)
- Prosthetic Devices (When Cost Exceeds $1,000)
- Reconstructive Procedures
- Rehabilitation Facility Services (Inpatient) Skilled Nursing Facility
- Sleep Apnea
- Surgery (Including Sleep Apnea, Orthognathic Surgeries, Blepharoplasty, Uvulopalaotopharyngoplasty and Vein procedures)
- Therapeutics (Outpatient) (Dialysis, Chemotherapy, Intravenous Infusion Therapy, Radiation Oncology, Intensity Modulated Radiation Therapy, MR-Guided Focused Ultrasound)
- Transplants

IMPORTANT REMINDERS

Network Providers are responsible for obtaining Prior Authorization from UnitedHealthcare before they provide certain services. However, there are some Network benefits for which You are responsible for obtaining prior authorization for the claims (i.e., nonemergency ambulance).

Non-Network Providers are NOT responsible for obtaining Prior Authorization, You, the Covered Person is responsible.

To initiate Prior Authorization, contact UnitedHealthcare by calling the toll-free number located on the back of Your ID card. Failure to obtain Prior Authorization on Covered Health Services Requiring Prior Authorization will result in a reduction of benefits or no benefits paid.

UnitedHealthcare - Health Advocacy and Support Programs

This section provides an overview of the health advocacy and support programs available, at no charge, with all of the
UnitedHealthcare Medical Plan options. To access all programs described in this section, contact UnitedHealthcare at the toll free number located on the back of Your ID card or email Advocate4Me@uhc.com.

UnitedHealthcare is available to help You:

- Understand how Your benefits work and get to the bottom of claims and benefits questions
- Determine which health screenings may be recommended for You
- Develop an action plan to help with issues including high blood pressure, high cholesterol, diabetes or back pain
- Locate Physicians, Specialists and facilities
- Learn more about treatment options and costs
- Reach Your wellness goals such as losing weight, quitting smoking or better managing stress

NURSELINE℠ - SPEAK WITH A NURSE

NurseLine is a toll-free telephone service that puts You in immediate contact with an experienced registered nurse any time, 24 hours a day, and seven days a week. Nurses can provide health information for routine or urgent health concerns. When You call, a registered nurse may refer You to any additional resources that ACME has available to help You improve Your health and well-being or manage a chronic condition. Call any time when You want to learn more about:

- Recent Diagnosis
- Minor sickness Or injury
- Men's, Women's, and Children's Wellness
- How To Take Prescription Drugs Safely
- Self-Care Tips and Treatment Options
- Healthy Living Habits
- Any Other Health Related Topic

NurseLine gives You another convenient way to access health information. By calling the same toll-free number, You can listen to one of the Health Information Library's over 1,100-recorded messages. NurseLine is available to You at no cost. To use this convenient service, simply call the toll-free number on the back of Your ID card.

- Dial 1-866-672-2511 and when prompted, say, “Speak to a Nurse”
- You may also live chat with a nurse on Your computer http://www.nurselinechat.com/ACMEcorp

DEDICATED NURSE ADVOCATES (DNA)

UnitedHealthcare offers You Dedicated Nurse Advocates (DNA) who assist You manage complex or chronic health conditions. You will be assigned to a nurse, and he/she will assist You every step of the way. Your assigned nurse will coordinate with Your treating Physician to help You coordinate care, answer Your questions, schedule appointments, discuss treatment plans, and more.

COMPLEX AND CHRONIC CONDITIONS

Gain access to support resources and top leading health care facilities in the nation. The UnitedHealthcare Centers of Excellence network provides access to leading health care facilities, Physicians, and services to support safe, specialized, and cost-effective care for complex conditions. Support programs available for complex and chronic conditions are listed below (in alphabetical order): □ Bariatric

- Cancer
- Congenital heart disease
- Back & spine
- Kidney
- Neonatal

- Transplant
- Wellness coaching

DIABETES MANAGEMENT PLUS THROUGH LIVONGO

UnitedHealthcare offers Diabetes Management Plus through Livongo to members with Type 1 or Type 2 diabetes. The program provides personalized support that helps You understand your blood sugar, develop healthy lifestyle habits, improve our glycemic control and offers additional support for comorbidities. The program offers:

- Connected devices to monitor and provide real-time feedback while enabling data collection.
- Coaching support from credentialed and experienced coaches who follow evidence-based practices to provide guidance and support.

To sign up for Diabetes Management Plus through Livongo visit well.livongo.com/ACME/now or call Livongo Member Support at (800) 945-4355 and mention registration code ACME.

MATERNITY SUPPORT PROGRAM

If You are pregnant or thinking about becoming pregnant, and You are enrolled in the medical Plan, You can get valuable educational information, advice and comprehensive case management by calling the number on Your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to You.

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the medical plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more. Post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, You are encouraged to enroll within the first trimester of pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on Your ID card.

As a program participant, You can always call Your nurse with any questions or concerns You might have.
The Fertility Solutions (FS) program provides a Network of Fertility treatment programs identified as Centers of Excellence. Through this program, FS can help Employees and Dependents work through questions relating to their specific medical circumstances and available treatment options. Refer to Fertility.

NEONATAL RESOURCE SERVICES (NRS)

NRS is a program administered by UnitedHealthcare or its affiliates made available to You. NRS provides a dedicated team of experienced Neonatologists, Neonatal Intensive Care Unit (NICU) nurse case managers and social workers who can provide support and assistance to You and Your family during your infant's admission to the NICU. The case manager will also provide discharge planning assistance and ongoing support post-discharge based on Your infant's needs. To take part in the NRS program, You or a covered Dependent can call the number on your ID card or call NRS directly at 1-866-534-7209.

MYUHC.COM

Manage Your benefits and health at myuhc.com:

- Track Claims and Expenses
- Pay Health Care Bills

- Find Network Providers and facilities
- Identify Physicians who have met quality and cost-efficiency guidelines through the UnitedHealth Premium® Designation
  Program[7]
- Locate and Compare Medications
- Refill Prescriptions
- Estimate Health Care Costs

HEALTH4ME®: UNITEDHEALTHCARE MOBILE APP

Download the mobile app, get access to Your benefits, and help anytime, anywhere. View Your virtual health plan ID card, check claim updates, find Network Providers and facilities, estimate costs, and get answers to Your questions.

RALLY: ONLINE HEALTH AND WELLNESS TOOL

Rally is a fun, interactive way to help make getting healthier fun. You will receive personalized recommendations to help get You moving more, eating better, feeling happier, and You will even have a chance to win great prizes. Go to myuhc.com. Once You are logged in, find "Rally" under the "Health and Wellness" tab, and begin. Rally is also available through online apps and wearables, such as Fitbit®, Jawbone® and BodyMedia®. Download the Rally app on iPhone® or Android.

- Your Rally Age: Answer a few easy questions and receive feedback about Your health
- Build Better Habits: Receive personalized recommendations
- Achieve Missions: Recommended "Missions" – activities designed to help You improve Your diet, fitness, and mood
- Win Cool Stuff: Earn Rally Coins, which You can use to enter sweepstakes to win great prizes

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Employee Assistance Program (EAP) is administered by United Behavioral Health (UBH). While the EAP is described in this Plan document and Summary Plan Description for convenience, the EAP is not part of the Plan. Services include confidential in-person counseling and online resources. EAP services are available to all eligible ACME Employees, eligible Dependents, and residents of Your household. Enrollment or use of one of the ACME medical plans is not required to access EAP services.

EAP Benefits and Limits

- EAP services cover ten (10) in-person counseling sessions, per concern, per Calendar Year
- Access the EAP through a toll-free number: 1-866-728-8413 Services are available 24 hours a day, seven days a week

EAP services provide resources to address topics including, but not limited to:

- Anxiety
- Depression
- Critical Incidents (e.g., natural disasters, terrorism)

[7] The UnitedHealthcare Premium Designation Program recognizes doctors who meet quality and cost efficiency guidelines. You can find a Physician's Premium Designation at myuhc.com.

- Financial and Legal Concerns
- Relationship Challenges
- Stress
- Substance Use Disorders

EAP Online Resources

EAP services include a wealth of online resources, articles, information, tools, and more. Find articles, resources, and tools to help You manage Your health and well-being. The Mental Health Condition Centers are a resource for day-to-day issues including depression, ADHD, and substance use disorders. Go to www.liveandworkwell.com and enter ACME's access code 228485.

EAP Cost Of Benefits

ACME pays 100% of EAP costs. This means, in-person counseling sessions (up to EAP limits), and on-line resources are all provided at no cost to You.

Kaiser Permanente HMO Plans

You may enroll in a Kaiser Permanente HMO Plan if You live in one of the service areas offered.

- Kaiser Permanente California (North and South)
- Kaiser Permanente Mid-Atlantic
- Kaiser Permanente Atlanta
- Kaiser Permanente Colorado
- Kaiser Permanente Oregon
- Kaiser Permanente Washington

Please refer to the Medical Plan Comparison Chart to view coverage details.

While the Kaiser Permanente HMO Plans are part of this Plan document and Summary Plan Description, it does not describe the provisions or limitations of the Kaiser Permanente HMO Plans. You will need to refer to the Evidence of Coverage issued by Kaiser Permanente. If there is a conflict between the Kaiser Permanente Evidence of Coverage and the other terms described in this document, the Kaiser Permanente Evidence of Coverage will supersede this Plan document and Summary Plan Description. All Kaiser Permanente HMO Evidences of Coverage and Group Agreements are incorporated herein by reference and are part of this Plan document and Summary Plan Description. The Evidence of Coverage documents for the Kaiser Permanente HMO Plans are available on the ACME US Benefits Website.

Covered Health Services - UnitedHealthcare Medical Plans

Covered Health Services (including Prescription Drugs and Mental Health) for all UnitedHealthcare Medical Plans are outlined and described below. Be sure to review each section carefully – taking note of Prior Authorization requirements (if applicable) and Plan Exclusions.

Refer to the Medical Plan Comparison Chart to view coverage details.

List of Covered Health Services (In Alphabetical Order)

ACUPUNCTURE

Acupuncture is a Covered Health Service when services are provided by an Acupuncturist who is practicing within the scope of his or her license or certification and the laws of jurisdiction when used for the treatment of:

- Chronic Pain
- Disease and injury

- Nausea resulting from Chemotherapy, Post Operation, or Pregnancy

Maintenance Acupuncture is not a Covered Health Service. See Exclusions.

ALLERGY TESTING

Charges associated with allergy diagnosis

ALLERGY TREATMENT

Charges associated with treating allergy conditions

AMBULANCE SERVICE – AIR AND GROUND (EMERGENCY)

Emergency ground or air ambulance transportation of Covered Person, to the nearest Hospital where Emergency Health Services can be performed (or in the case of an organ transplant, to the Hospital where the transplant will occur). The ambulance must be from a licensed ambulance service.

AMBULANCE SERVICE – AIR AND GROUND (NON-EMERGENCY)

IMPORTANT: Prior Authorization is required.

Non-Emergency ground or air ambulance transportation of Covered Person, to a health care facility by a licensed ambulance service, and the transport is deemed appropriate and Medically Necessary by UnitedHealthcare – and when the Covered Person is transported:

- from a Non-Network Hospital to a Network Hospital;
- to a Hospital that offers a high care level that is not available at the original Hospital;
- to a more cost-effective acute care facility;
- in the case of an organ transplant, to the Hospital where the transplant will occur; or from an acute facility to a sub-acute setting.

Eligible Expenses for Air Ambulance transport provided by a Non-Network Provider will be determined as described in the definition of Eligible Expenses.

ANESTHETICS AND OXYGEN

Related charges for Inpatient and Outpatient services.

ARTIFICIAL LIMBS AND EYES

IMPORTANT: Prior Authorization is required for prosthetic device exceeding $1,000

Prosthetic devices and surgical implants are covered when used consistent with accepted medical practice and approved for use by the FDA. Repair or replacement is also covered, unless necessitated by misuse or loss.

AUTISM SPECTRUM DISORDER (AUTISM)

IMPORTANT: Prior Authorization is required.

The benefits described in this section include the medical and Mental Health Services for Autism Spectrum Disorders (and covered diagnosis – see below). See Exclusions.

The following diagnoses are covered by the Autism Spectrum Disorder Covered Health Services. Diagnosis of the Covered Person must be validated to be eligible for Covered Health Services.

- Autism
- Asperser's Disorder
- Pervasive Developmental Disorder Not Otherwise Specified (PDD NOS)
- Childhood Disintegrative Disorder
- Rett's Disorder

AUTISM – COVERED HEALTH SERVICES (MEDICAL)

Medical Plan – Covered Health Services

- Intensive Behavioral Therapy
- Applied Behavioral Analysis (ABA)
- Occupational Therapy
- Physical Therapy
- Speech Therapy

Eligible Providers

- Providers who have met established qualifications of a Board Certified Behavioral Analyst
- Clinically Licensed Mental Health Clinicians with a Doctorate or Master's degree that are trained to treat Autism Spectrum Disorders using Intensive Behavior Therapies
- Providers who perform services under the direct supervision of a "eligible" Providers (e.g., therapy assistants)

AUTISM – COVERED HEALTH SERVICES (MENTAL HEALTH)

IMPORTANT: Prior Authorization is required.

The benefits described in this section are provided by the Mental Health Services offered through United Behavioral Health (UBH).

The Plan pays benefits for Mental Health Services for Autism Spectrum Disorders that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric Provider; and
- Is focused on treating maladaptive and stereotypic behaviors that are posing danger to self, others or property, and impairment in daily functioning.

Covered Health Services include the following on an Outpatient or Inpatient basis

- Diagnostic Evaluations and Assessment
- Treatment Planning
- Referral Services
- Medication Management
- Individual, Family, Therapeutic Group and Provider-Based Case Management Services Crisis Intervention

Covered Health Services include the following on an Inpatient basis only

- Partial Hospitalization - Day Treatment
- Residential Treatment Facility Services

Covered Health Services include Intensive Outpatient Treatment on an Outpatient basis only

BIRTH CONTROL DEVICES/ORAL CONTRACEPTIVES

See Contraceptives.

BIRTHING CENTER

Is a facility that:

- Meets licensing standards,
- Is established and equipped to provide prenatal care, delivery and postpartum care,
- Is directed by an OB/GYN Physician,
- Has a Physician or certified nurse midwife present at all births,
- Has at least two beds and two birthing rooms,
- Provides full-time Skilled Nursing services directed by an RN or certified nurse midwife,
- Has the capacity to administer a local anesthetic and to perform minor surgery,
- Is equipped and has trained staff to handle medical emergencies and to provide immediate support measures to sustain life if complications arise during labor or if a Child is born with birth defects,
- Accepts only low-risk pregnancies,
- Has a written agreement with a Hospital in the area for Emergency transfer of a patient or a Child,
- Provides an ongoing quality assurance program which includes reviews by Physicians who do not own or direct the facility, and
- Keeps a medical record on each patient.

BREAST PUMPS

To rent or purchase breast pumps, You will simply need to contact a Network Physician or Durable Medical Equipment (DME) supplier. UnitedHealthcare has contracted with national DME suppliers who can ship the breast pump directly to You. The Physician or DME supplier will bill UnitedHealthcare directly for reimbursement. For quality products, easy accessibility, convenience, and portability, You should purchase personal double-electric breast pumps without cost-share through one of UnitedHealthcare's Network Providers.

In addition to renting or purchasing a breast pump from Your Network Physician, You may also contact one of UnitedHealthcare's DME suppliers. Contact UnitedHealthcare for a complete list of suppliers.

If more than one breast pump can meet Your needs, Benefits are available only for the most cost effective pump. UnitedHealthcare will determine the following:

- Which pump is the most cost effective;
- Whether the pump should be purchased or rented;
- Duration of a rental;
- Timing of an acquisition;

You must access supplies through one of the UnitedHealthcare suppliers. You will NOT be able to purchase supplies, such as breast pumps, at retail and submit the receipt for reimbursement.

CANCER RESOURCE SERVICES

Access to Network Providers participating in the Cancer Resource Services Program for the provision of oncology services. The oncology services include Covered Health Services and Supplies rendered for the treatment of a condition that has a primary or suspected diagnosis relating to cancer.

CELLULAR AND GENE THERAPY

IMPORTANT: Prior Authorization is required.

Cellular Therapy and Gene Therapy received in-network on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under Transplant Services.

CHIROPRACTIC CARE

Refer to Spinal Manipulation.

COCHLEAR IMPLANTS

Coverage is available for cochlear implants, surgery, and therapy when associated with a medical condition.

CLINICAL TRIALS

IMPORTANT: Prior Authorization is required.

Coverage includes the routine costs for items and services furnished in connection with participation in an approved Clinical Trial when the following criteria are met:

- The person is eligible to participate in an approved Clinical Trial according to the trial protocol; and the Clinical Trial is for the treatment of cancer or another life-threatening disease or condition; and
- the referring health care professional is a Network Provider; and
- the Network Provider (referring health care professional) provides medical and scientific information; and determines the patient's participation in the Clinical Trial is appropriate.

CONTRACEPTION METHODS AND COUNSELING

Women, with reproductive capacity, are eligible for certain Covered Health Services, without cost-share - so long as the Covered Health Services are performed by a Network Provider. This means the designated Covered Health Services are **free of charge** – and not applicable to Plan Copayments, Deductibles, and Coinsurance. The following Covered Health Services are available to women and free of charge, when Network Providers are used.

Covered Health Services (Free of Charge When Network Providers Are Used)

- Prescribed FDA-Approved Contraception Methods
- Sterilization Procedures
- Patient Education
- Counseling

Male Contraception: Male contraception and sterilization procedures are Covered Health Services under the Plan. However, the zero cost provision applicable to women does not apply to male contraception and sterilization procedures. The Covered Person will be responsible for the applicable Plan Copayments, Deductibles, and Coinsurance.

Excluded: Condoms and spermicidal agents are not Covered Health Services because they are available without a prescription.

CONVALESCENT CARE

Refer to "Skilled Nursing Facility Care"
IMPORTANT: Prior Authorization is required.

CRANIAL BAND/HELMET

Refer to “Orthotics”

DENTAL SERVICES – ACCIDENTAL ONLY

- Accidental Dental Services are limited to the following:
- Emergency Examination
- Necessary Diagnostic X-Rays
- Endodontic (Root Canal) Treatment
- Temporary Splinting of Teeth
- Prefabricated Post and Core
- Simple Minimal Restorative Procedures (Fillings)
- Extractions
- Post-traumatic crowns if such are the only clinically acceptable treatment
- Replacement of lost teeth due to the injury by implant, dentures or bridges

Dental damage due to normal activities of daily living or extraordinary use of the teeth, are not considered “accidental.” The benefits listed above are not covered unless the requirements (below) are met.

Accidental Dental Services are Covered Health Services when all of the following are true:

- Treatment is necessary because of accidental damage; and
- Dental services are received from a Doctor of Dental Surgery, “D.D.S.” or Doctor of Medical Dentistry, “D.M.D”; and
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident; and
- The Physician or dentist certifies the injured tooth is a virgin or un-restored tooth, or a tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant, and functions normally in chewing and speech; and
- Treatment is for a sound and natural tooth; and
- Dental services are for final treatment to repair the damage and ○ starts within three months of the “accidental event”; and ○ treatment is completed within 12 months of the “accidental event.”

DENTAL SURGERY ANESTHESIA – ACCIDENTAL ONLY

Also referred to as “Oral Surgery Anesthesia”

- Covered Health Services in connection with general anesthesia and associated facility charges for dental procedures are payable when performed by or under the direction of a Physician – and when the Covered Person meets one or more of the following:
- The Covered Person is under six years of age or under six years of age in maturity
- The treating Physician asserts general anesthesia is necessary to protect the Covered Person’s health
- The treating Physician affirms the Covered Person is developmentally disabled
- The treating Provider affirms the Covered Person has a non-dental, hazardous physical condition (e.g. Heart Disease or
- Hemophilia) that makes general anesthesia for that person necessary

- Coverage for the anesthesia and associated facility charges are subject to the same terms and conditions applied to other Covered Health Services. The terms and conditions include but not limited to Deductible, Coinsurance, and Copayments
- Charges for a Non-Accidental Dental procedure, including but not limited to the professional fees of the dentist, are not covered. This exclusion does not apply to dental care required for the direct treatment of a medical condition for which benefits are available under the Plan (e.g., cancer).

DOCTOR (PHYSICIAN) OFFICE VISITS

Refer to “Physician’s Office Services”

DURABLE MEDICAL EQUIPMENT (DME)

IMPORTANT: Prior Authorization is required if single device rental or purchase cost exceeds $1,000.

Durable Medical Equipment is covered if each of the following criteria is met:

- It is determined that, due to sickness or accidental injury, the Covered Person requires the DME device,
- ordered or provided by a Physician for Outpatient use; and the Physician certifies the DME will serve a medical purpose, and is not consumable or disposable.
- Coverage for scooters is covered under the Plan as Durable Medical Equipment, if each of the following criteria is met: ○ It is determined that, due to sickness or accidental injury, the Covered Person requires the use of a scooter, and a Physician certifies the scooter will serve a medical purpose; and ○ The scooter will be subject to the maximum benefit provisions for DME; and ○ Prior Authorization will determine and approve purchase or rental of scooter; and ○ To receive Network benefits, the Covered Person must purchase or rent the approved scooter from the recommended UnitedHealthcare vendor.
- If the Covered Person’s functional needs can be met by more than one DME device - benefits are available for the most costeffective device only. The Plan does not cover the charge for more than one DME device that offers the same or similar purpose.
- The Plan provides benefits for a single unit of DME (e.g., one insulin pump) and provide repair for that unit.
- The replacement of DME, are covered once every three Calendar Years.
- UnitedHealthcare will cover DME rental.
- DME may be purchased if UnitedHealthcare approves the purchase and it is shown that: ○ DME device will be used long term, and ○ Covered Person cannot rent the equipment; or ○ it will cost less to buy than to rent it.

To receive Network Benefits, You must obtain the Durable Medical Equipment or orthotic from the vendor UnitedHealthcare identifies or from the prescribing Network Physician. **Examples (DME)**

- Equipment to assist mobility, such as a standard wheelchair
- A standard hospital-type bed
- Oxygen concentrator units and the rental of equipment to administer oxygen
- Delivery pumps for tube feedings (including tubing and connectors)
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions Gauze and Dressings

EMERGENCY SERVICES

Plan coverage for the treatment received at a Network and Non-Network Emergency Room are the same. A Covered Person does not receive a reduced benefit when care is received at a Non-Network hospital, if treatment is a result of a true Emergency. If treatment is a result of a Non-Emergency, services are subject to the Plan's Network and Non-Network Deductible and Coinsurance. For Plans that do not cover Non-Network Services (EPO and Harvard Pilgrim Passport Plan), the Plan will not pay benefits for non-Emergency services provided in an Emergency Room unless authorized by the Covered Person's Plan Provider.

Emergency Notification Requirement

If a Covered Person is admitted into the Hospital following Emergency Room treatment, the Covered Person, the Covered Person's Physician, the Hospital, or a family member are required to notify UnitedHealthcare within two business days (or as soon as reasonably possible) of the Covered Person's Hospital admittance.

Emergency Services (Non-US)

Emergency services received outside of the United States are covered at the Network level. The applicable Network Deductible, Coinsurance, Copayments apply.

Non-Emergency Services (Non-US)

Non-Emergency Covered Health Services received outside of the United States are covered at the Non-Network coverage level. The applicable Non-Network Deductible and Coinsurance will apply to billed charges. The medical plans that do not cover Non-Network Covered Health Services (UnitedHealthcare EPO Plan, UnitedHealthcare Harvard Pilgrim Passport Plan, and Kaiser Permanente HMO Plans) will cover Emergency Services only – and any non-Emergency services will not be covered.

Filing Non-US Claims can be more complicated than a regular US claim due to language and currency conversion and/or the receipt of additional information required to process the claim and may take longer to process. To have Your non-US claim reviewed and processed, it is important that You complete the following:

- Complete the UnitedHealthcare International Claim Form
- Attach the original claim, itemized bills, medical records, and proof of payment
- If possible, ask the Provider/Physician to write the bills in English and convert foreign currency to US dollars

ENTERAL NUTRITION

Benefits are provided for enteral formulas and low protein modified food products, administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. Examples of conditions include:

- Metabolic diseases such as phenylketonuria (PKU) and maple syrup urine disease.
- Severe food allergies.
- Impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract.

Benefits for prescription or over-the-counter formula are available when a Physician issues a prescription or written order stating the formula or product is Medically Necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. The formula or product must be administered under the direction of a Physician or registered dietitian.

For the purpose of this benefit, "enteral formulas" include:

- Amino acid-based elemental formulas.

- Extensively hydrolyzed protein formulas. Modified nutrient content formulas.

For the purpose of this benefit, "severe food allergies" mean allergies which if left untreated will result in:

- Malnourishment.
- Chronic physical disability. Intellectual disability; or Loss of life.

FAMILY PLANNING

Charges made by a Hospital or Physician, even though they are not provided in conjunction with the diagnosis or treatment of a disease or injury. Benefits are payable for: (1) a vasectomy for voluntary sterilization, (2) a tubal ligation for voluntary sterilization and
(3) legal abortions (includes therapeutic and elective).

FERTILITY

Fertility Solutions Program

The Fertility Solutions Program can provide You with support and coverage as You pursue fertility treatments.

Fertility Solutions program provides:

- Specialized clinical consulting services to You and enrolled Dependents to educate on fertility treatment options.
- Access to specialized Network facilities and Physicians for fertility services.
- Provides education, specialized clinical counseling, treatment options and access to national Network of premier fertility treatment clinics.

The Plan pays Benefits for the fertility services described below when provided by Designated Providers participating in the Fertility Solutions program.

Covered Persons who do not live within a 50 mile radius of a Fertility Solutions Designated Provider will need to contact a Fertility Solutions case manager to determine a Network Provider prior to starting treatment.

For Fertility Services and supplies to be considered Covered Health Services through this program, contact Fertility Solutions and enroll with a nurse consultant prior to receiving services.

You or a covered Dependent may:

- Be referred to Fertility Solutions by UnitedHealthcare.
- Call the telephone number on your ID card.
- Call Fertility Solutions directly at 1-866-774-4626.

To take part in the Fertility Solutions program, call a nurse at 1-866-774-4626. The Plan will only pay Benefits under the Fertility Solutions program if Fertility Solutions provides the proper notification to the Designated Provider performing the services (even if you self-refer to a Provider in that Network).

Fertility Services

Therapeutic services for the treatment of fertility when provided by or under the direction of a Physician. Benefits under this section are limited to the following procedures:

- Assisted Reproductive Technologies (ART), including but not limited to in vitro fertilization (IVF). ART procedures include, but are not limited to:
    - Egg/oocyte retrieval. Fresh or frozen embryo transfer.
    - Intracytoplasmic sperm injection - ICSI.
    - Assisted hatching. Cryopreservation and storage of embryos for up to 12 months. Embryo

biopsy for PGT-M or PGT-SR (formerly known as PGD).

- Frozen Embryo Transfer cycle including the associated cryopreservation and storage of embryos for 12 months.
- Intracytoplasmic sperm injection (ICSI).
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Ovulation induction (or controlled ovarian stimulation).
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Surgical Procedures, including but not limited to: Laparoscopy, Lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, resection and ablation of endometriosis, transcervical tubal catheterization, ovarian cystectomy.
- Electroejaculation.
- **Pre-implantation Genetic Testing for a Monogenic Disorder (PGT-M) or Structural Rearrangement (PGT-SR)** - when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo.
- **Fertility Preservation for Medical Reasons** - when planned cancer or other medical treatment is likely to produce
  Infertility/sterility. Coverage is limited to: collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, in vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.
- **Embryo biopsy for Pre-implantation Genetic Testing for Aneuploidy (PGT-A)** used to select embryos for transfer in order to increase the chance for conception.
- **Fertility Preservation for Non-Medical Reasons** - when You would like to delay pregnancy for non-medical reasons. Coverage is limited to: collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, in vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

Treatment for the diagnosis and treatment of any underlying cause of Infertility is covered as described in this document. Benefits for diagnostic tests are described under, Outpatient Surgery, Diagnostic and Therapeutic and Physician's Office Services.

Prescription Drug Coverage Fertility medications are filled in accordance with and subject to the same Plan requirements as the Plan's Prescription Drug coverage. Refer to "Prescription Drugs."

Refer to the Medical Plan Comparison Chart to view Plan coverage.

There is no limit for medical services and Prescription Drugs for fertility related services; however, You must enroll in the Fertility Solutions Program and receive services from a UHC Fertility Center of Excellence. To enroll, You can call the Fertility Solutions Program Nurse Team at 866-774-4626.

Criteria to be eligible for Benefits
You do not need to have a diagnosis of Infertility in order to be eligible to receive the services described above.

You must enroll in the Fertility Solutions Program and receive services from a UHC Fertility Center of Excellence. To enroll, You can call the Fertility Solutions Program Nurse Team at 866-774-4626.

FERTILITY PRESERVATION FOR IATROGENIC INFERTILITY

Benefits are available for fertility preservation for medical reasons that cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Services include the following procedures, when provided by or under the care or supervision of a Physician: Collection of sperm.

- Cryo-preservation of sperm.
- Ovarian stimulation, retrieval of eggs and fertilization.
- Oocyte cryo-preservation.
- Embryo cryo-preservation.
- Storage up to one year.

Benefits are not available for long-term storage costs (greater than one year).

GENDER DYSPHORIA

IMPORTANT: Prior Authorization is required.

Benefits for the medically necessary treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

Surgical treatment

- You must obtain prior authorization as soon as the possibility of surgery arises.
- If You fail to obtain prior authorization as required, the benefits will be subject to a $200 penalty.
- In addition, for out-of-network benefits You must contact UnitedHealthcare 24 hours before admission for an inpatient stay. Non - Surgical treatment
- You must obtain prior authorization.

Benefits for the treatment of Gender Dysphoria are limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided as described under Mental Health Services.
- Cross-sex hormone therapy: ○ Cross-sex hormone therapy administered by a Provider (for example during an office visit) as described under Injections in a Physician's office.
    - ○ Cross-sex hormone therapy dispensed from a pharmacy as described under Prescription Drugs.
    - ○ Puberty suppressing medication injected or implanted by a Provider in a clinical setting.
    - ○ Laboratory testing to monitor the safety of continuous cross-sex hormone therapy. Voice modification therapy

Surgery for the treatment for Gender Dysphoria, including but not limited to the surgeries listed below:

- Bilateral mastectomy or breast reduction
- Clitoroplasty (creation of clitoris)
- Hysterectomy (removal of uterus)
- Labiaplasty (creation of labia)
- Metoidioplasty (creation of penis, using clitoris)
- Orchiectomy (removal of testicles)
- Penectomy (removal of penis)
- Penile prosthesis
- Phalloplasty (creation of penis)

- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of urethra)
- Vaginectomy (removal of vagina) Vaginoplasty (creation of vagina)
- Vulvectomy (removal of vulva)
- Breast augmentation
- Thyroid chondroplasty (removal or reduction of the Adam's Apple)
- Voice modification surgery
- Electrolysis or laser hair removal of the face
- Electrolysis or laser hair removal of skin graft for genital surgery
- Facial surgery (such as facial bone reduction, jaw reconstruction, etc.)
- Neck tightening and face lift only following alteration of underlying skeletal structures

Genital Surgery, Bilateral Mastectomy or Breast Reduction Surgery, and Facial Surgery Documentation Requirements:

You must provide documentation of the following for breast surgery and facial surgery:

- A written psychological assessment from at least one qualified health professional experienced in treating Gender Dysphoria. The assessment must document that You meet all of the following criteria:
    - Persistent, well-documented Gender Dysphoria. ○ Capacity to make a fully informed decision and to consent for treatment.
    - Must be 18 years or older unless You meet the criteria under COVERAGE FOR CHILD UNDER THE AGE OF MAJORITY (see below).
    - If significant medical or mental health concerns are present, they must be reasonably well controlled.

You must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified health professionals experienced in treating Gender Dysphoria, who have independently assessed You. The assessment must document that You meet all of the following criteria. ○ Persistent, well-documented Gender Dysphoria. ○ Capacity to make a fully informed decision and to consent for treatment.
    - Must be 18 years or older unless You meet the criteria under COVERAGE FOR CHILD UNDER THE AGE OF MAJORITY (see below) ○ If significant medical or mental health concerns are present, they must be reasonably well controlled. ○ Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
    - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated or not indicated for the desired gender).

Covered Health Services are based on UnitedHealthcare Medical Guidelines (with the exception of facial surgeries). In addition to the surgeon fees, Covered Health Services include the services related to the surgery, including, but not limited to: anesthesia, laboratory testing, pathology, radiologic procedures, hospital and facility fees, and/or surgical center fees.

COVERAGE FOR CHILD UNDER THE AGE OF MAJORITY (based on state law)
An eligible dependent Child who may not give consent to medical treatment under state law is eligible for puberty-suppressing hormone treatment and/or gender dysphoria surgeries if the following conditions are met:

Criteria for puberty-suppressing hormones:

- The Child has been diagnosed with persistent and well-documented Gender Dysphoria (see the definitions) by a qualified mental health professional;
- If significant medical or mental health concerns are present, they must be reasonably well controlled;
- All parental consents required by law have been obtained;
- The Child must be in the earliest stages of puberty (i.e., Tanner stages 2 or 3);
- The Child must demonstrate that he/she is able to provide an educated and informed consent for the treatment; The Child's parents must sign an ACME-approved Indemnification and Hold Harmless Agreement; and Criteria for surgery:
- The Child has been diagnosed with persistent, well-documented Gender Dysphoria (see the definitions) by a qualified mental health professional;
- If significant medical or mental health concerns are present, they must be reasonably well controlled;
- The Child is within a year of the age of majority;
- All parental consents required by law have been obtained;
- The Child must demonstrate that he/she is able to provide an educated and informed consent for the irreversible (and related) medical treatments;
- The Child's parents must sign an ACME-approved Indemnification and Hold Harmless Agreement;
- The Child must live continuously for at least 12 months in the gender role that is congruent with the Child's gender identity and be continuously covered under the Plan during that time; and
- Complete 12 months of continuous hormone therapy appropriate for the desired gender (unless medically contraindicated or not indicated for the desired gender).

GYNECOMASTIA

IMPORTANT: Prior Authorization is required.
Surgery for treatment of gynecomastia (male breast enlargement) is covered if the surgery is Medically Necessary and meets the UnitedHealthcare Medical Guidelines, regardless of age.

HEARING AIDS

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider. Benefits are provided for the hearing aid and associated fitting charges and testing.

Benefits are also provided for certain over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss.

Benefits for over-the-counter hearing aids do not require any of the following:

- A medical exam.
- A fitting by an audiologist.
- A written prescription.

Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear and is once every three years.

HOME HEALTH CARE

IMPORTANT: Prior Authorization is required.

Services received from a Home Health Agency that meets both of the following criteria:

- Ordered by a Physician; and
- Services performed by or supervised by a registered nurse in Covered Person's home Limited to 100 visits per calendar year.

Benefits are available only when the Home Health Agency services performed on a part-time, intermittent schedule, and when Skilled Home Health Care is required by a medical professional.

Skilled Home Health Care is Skilled Nursing, teaching, and rehabilitation services when all of the following are true:

- Care must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient; and
- Care is ordered by a Physician; and
- Care requires clinical training in order to be delivered safely and effectively, and
- Care is not delivered for the purpose of assisting with activities of daily living (ADL), including but not limited to dressing, feeding, bathing, or transferring from a bed to a chair. These services are considered Custodial Care – and not covered by the Plan.

HOSPICE CARE

IMPORTANT: Prior Authorization is required.

Covered Hospice Care charges include Hospital, hospice or convalescent facility for Inpatient room and board, and medical services and supplies for pain control and other acute and chronic symptom management for a terminally ill person. Charges include psychological and dietary counseling, and physical and occupational therapy. You or Your Provider must notify UnitedHealthcare prior to receiving services. Hospice services cover a period of up to six months. Bereavement counseling is limited to 15 visits per calendar year (combined Network Providers and Non-Network Providers). Prior Authorization Requirement – Please be advised that this service requires that You notify UnitedHealthcare.

Hospice Care needs to be recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed Hospice Care Agency. Benefits are available up to a six months Maximum Lifetime Benefit.

HOSPICE CARE AGENCY

IMPORTANT: Prior Authorization is required.

An agency or organization which:

- Has hospice care available 24 hours a day,
- Meets any state and/or local licensing or certification standards, And Provides:
- Skilled Nursing Services
- Medical Social Services

- Psychological and Dietary Counseling
- Bereavement Counseling For the Immediate Family And Provides or arranges for other services including:
  - Services of a Physician
  - Physical or occupational therapy
  - Part-time home health aide services
  - Inpatient care in a facility when needed for pain control
  - Has on staff a Physician, an RN, a licensed or certified social worker and a counselor,
  - Keeps a medical record on each patient,
  - Has a full-time administrator, and
  - Provides an ongoing quality assurance program, including reviews by Physicians, other than those who own or direct the Agency.

Covered Charges for Hospice Care do not include:

- Funeral Arrangements
- Pastoral, Financial or Legal Counseling
- Homemaker or Caretaker Services
- Respite Care

HOSPITAL

IMPORTANT: Prior Authorization is required.

- The UnitedHealthcare Medical Plans cover charges if the Hospital:
- is a licensed facility; and
- provides Inpatient facilities for the surgical and medical diagnosis, treatment and care of injured and sick persons; and
- is supervised by a staff of Physicians; and
- provides 24-hour RN services; and
- is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home; and
- is necessary to prevent, diagnose, or treat the sickness or injury of a Covered Person

HYPERHIDROSIS

Treatment of hyperhidrosis that meets the UnitedHealthcare Medical Guidelines.

IMMUNIZATIONS

All standard preventive Immunizations recommended by the Advisory Committee on Immunization Practices are covered without cost share – when Network Providers are used.

INJECTIONS IN A PHYSICIAN'S OFFICE

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified Provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, benefits will be provided for administration of the Pharmaceutical Product under the corresponding benefit category in this document. Benefits for medication normally available by prescription or order or refill are provided as described under Prescription Drugs. Benefits under this section do not include medications for fertility.

If You require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct You to a designated dispensing entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such dispensing entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency Provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If You/Your Provider are directed to a designated dispensing entity and You/Your Provider choose not to obtain Your Pharmaceutical Product from a designated dispensing entity, Network benefits are not available for that Pharmaceutical Product.

UnitedHealthcare may have certain programs in which You may receive an enhanced or reduced benefit based on Your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on your ID card.

MAMMOGRAMS

Charges for mammography screening for the presence of breast cancer. Mammography may be done at the intervals established by the American College of Obstetrics and Gynecologists. Visit the United States Preventive Task Force website to find out more information on screening intervals.

If You have a family history of breast cancer, mammograms will be covered on a more frequent basis regardless of Your age, when prescribed by Your Physician. You will need to contact Your Physician if You feel You qualify for intervals that are more frequent.

Refer to the Medical Plan Comparison Chart to view plan details.

MATERNITY CARE

IMPORTANT: Prior Authorization is required.

Charges incurred by a covered female for prenatal care, delivery and newborn nursery care. This benefit includes charges made by a birthing center, which includes Physician charges, prenatal care, anesthesia, delivery, and postpartum care provided within 48 hours of delivery. Also covered are charges by a midwife when licensed and accepted under the state law. The UnitedHealthcare Plans cover all maternity and pregnancy-related services for all female Covered Persons.

Benefits will not be restricted 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 and 96 hours following a cesarean section delivery. A female Covered Person may elect a shorter Hospital stay if the attending Provider (e.g., Your Physician or nurse midwife), after consultation with the female Covered Person, discharges the female Covered Person or newborn earlier.

MENTAL HEALTH BENEFITS

Your medical coverage provides physical care and provides assistance when You need counseling or help with personal, emotional, and mental health challenges.

Mental Health – Medical Plan Coverage

Mental Health services are available through ACME's UnitedHealthcare and Kaiser Permanente Plans.

MENTAL HEALTH SERVICES FOR AUTISM SPECTRUM DISORDER

See “Autism Spectrum Disorder”

MENTAL HEALTH, NEUROBIOLOGICAL DISORDERS, AND SUBSTANCE-RELATED AND ADDICTIVE DISORDERS SERVICES

Inpatient and Outpatient diagnosis and authorized treatment for alcoholism, drug abuse, and mental neurobiological disorders. IMPORTANT: Prior Authorization is required.

Covered Mental Health Services

- Day Treatment Services At a Residential Treatment Facility
- Inpatient Services
- Outpatient Treatment (Electro-Convulsive)
- Outpatient Treatment (Extended) with or without Medication Management
- Outpatient Treatment (Intensive)
- Partial Hospitalization
- Psychological Testing
- Inpatient Treatment and Residential Treatment includes room and board in a semi-private room (a room with two or more beds).
- Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders:
  - Inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility); ○ Intensive Outpatient program treatment; ○ Outpatient electro-convulsive treatment; ○ Psychological testing; ○ Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA) ○ Inpatient Treatment and Residential Treatment includes room and board in a semi-private room (a room with two or more beds)
- Substance-Related and Addictive Disorders Services ○ Inpatient Services; ○ Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); ○ intensive Outpatient program treatment; ○ Outpatient electro-convulsive treatment; ○ psychological testing;
  - Inpatient Treatment and Residential Treatment includes room and board in a semi-private room (a room with two or more beds)

What is Covered Under Mental Health Services

Mental Health Services include those received on an Inpatient basis in a Hospital or Alternate Facility, and those received on an Outpatient basis in a Provider’s office or at an Alternate Facility.

Benefits include the following services provided on either an Outpatient or Inpatient basis:

- Diagnostic evaluations assessment and treatments and/or procedures;
- Referral services;
- Medication management;
- Individual, family and group therapy;
- Crisis intervention.

Psychological and neuropsychological test is covered if all of the following are true:

- You have been seen for an initial evaluation by a licensed mental health professional
- The purpose of testing is to address a specific referral question that could not otherwise be answered by a standard clinical interview/evaluation and meets the United Behavioral Health psychological and neuropsychological guideline criteria for notification

- The testing is conducted or supervised by an independently licensed psychologist
- The tests and number of hours requested are consistent with the reason for testing

Benefits include the following services provided on an Inpatient basis:

- Partial Hospitalization/Day Treatment; and services at a Residential Treatment Facility.

Benefits include the following services provided on an Outpatient basis: Intensive Outpatient Treatment.

Substance-Related and Addictive Disorders – Covered Health Services

Substance-Related and Addictive Disorders Services include those received on an Inpatient basis in a Hospital or an Alternate Facility and those received on an Outpatient basis in a Provider's office or at an Alternate Facility. Benefits for Substance-Related and Addictive Disorders Services include the following services provided on either an Inpatient or an Outpatient basis:

- diagnostic evaluations, assessment and treatment and/or procedures;
- referral services;
- medication management;
- individual, family, and group therapy;
- crisis intervention; and
- detoxification (sub-acute/non-medical).
- Benefits include the following services on an Inpatient basis: ○ Partial Hospitalization/Day Treatment; and services at a Residential Treatment Facility.
- Benefits include the following services on an Outpatient basis:
  - Intensive Outpatient Treatment.

Coverage for Inpatient alcohol and drug abuse treatment is provided when the facility:

- Mainly provides a program for diagnosis, evaluation, and effective treatment of alcoholism or drug abuse,
- Makes charges for services,
- Meets licensing standards,
- Prepares and maintains a written plan of treatment for each patient. The Plan must be based on medical, psychological and social needs and must be supervised by a Physician, and Provides, on the premises, 24 hours a day:
  - Detoxification services needed with its effective treatment program ○ Infirmary-level medical services. In addition, it provides or arranges with a Hospital in the area for any other services that may be required. ○ Supervised by a staff of Physicians.
  - Skilled nursing care by licensed nurses who are directed by a full-time RN.

The UnitedHealthcare Medical Plans cover effective treatment of alcohol or drug abuse. This means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a Physician and either:

- Has a follow-up therapy program directed by a Physician on at least a monthly basis, or
- Includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

Benefits include detoxification from abusive chemicals or substances that is limited to physical detoxification when necessary to protect Your physical health and well-being.

A mental disorder is a disease, 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 who is properly licensed and qualified by law and acting within the scope of their licensure such as a psychiatrist, a psychologist, or a psychiatric social worker.

A mental disorder includes but is not limited to:

- Alcoholism and drug abuse (except when a separate benefit applies to treatment of these conditions),
- Schizophrenia,
- Bipolar disorder,
- Pervasive mental developmental disorder (Autism),
- Panic Disorder,
- Major Depressive Disorder,
- Psychotic Depression, and
- Obsessive-Compulsive Disorder.

Coverage for Inpatient treatment of mental disorders is provided when the facility is a licensed crisis stabilization unit or a licensed Residential Treatment Center, or when the facility meets all of the following conditions:

- Mainly provides a program for the diagnosis, evaluation, and effective treatment of mental disorders. Effective treatment describes a program that is:
  - Prescribed and supervised by a Physician, and
  - Is for a disorder that can be favorably changed.
- Makes charges for services.
- Meets licensing standards.
- Is not mainly a school or a custodial, recreational, or training institution.
- Provides infirmary-level medical services. In addition, it provides or arranges with a Hospital in the area for any other medical services that may be required.
- Is supervised full-time by a psychiatrist who is responsible for patient care and who is on-site regularly.
- Is staffed by psychiatric Physicians involved in care and treatment. A psychiatrist is a Physician who:
  - specializes in psychiatry, or
  - has the training and experience to do the required evaluation and treatment of mental illness.
- Has a psychiatric Physician present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides, at all times, Skilled Nursing care by licensed nurses who are supervised by a full-time RN.
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological, and social needs. A psychiatric Physician must supervise the plan.

Treatment for mental disorders and/or alcoholism or drug abuse may include one or more of the following kinds of treatment:

- Day Care Treatment - a partial confinement treatment program given to a person during the day. There is no room charge made by the Hospital or treatment facility. A day care program must be available for at least four hours but not more than eight hours in any 24-hour period.
- Night Care Treatment - a partial confinement treatment program given to a person who is confined during the night. A room charge is made by the Hospital or treatment facility. A night care program must be available at least four hours but not more than eight hours in any 24-hour period.
- Partial Confinement Treatment - a plan of psychiatric services to treat a mental disorder which meets the following conditions:
  - It is carried out in a Hospital or treatment facility on less than a full-time Inpatient basis,

- It is in accord with accepted medical practice for the condition of the person and does not require full-time confinement, and ○ It is supervised by a psychiatric Physician who reviews and evaluates the treatment on a weekly basis.

- Inpatient Treatment and Residential Treatment includes room and board in a Semi –private Room (a room with two or more beds)

NON-OCCUPATIONAL INJURY OR DISEASE

An accidental bodily injury or disease 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 or disease which does.

Occupational injuries and diseases are generally covered under Workers' Compensation, not the medical plans. However, the UnitedHealthcare Plans will cover a medical condition, regardless of its cause, if UnitedHealthcare receives proof that the person is covered under a Workers' Compensation law that does not cover that disease.

NUTRITIONAL COUNSELING

Nutritional counseling for both preventive and non-preventive conditions if both of the following requirements are met:

- Nutrition education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit regarding the disease that requires the intervention of a trained health professional.

Examples may include, but are not limited to: Participants with Diabetes Mellitus, Coronary Artery Disease, Congestive Heart Failure, Severe Obstructive Airway Disease, Gout, Renal Failure, Phenylketonuria, and Hyperlipidemia.

Nutritional Counseling is not covered for the following:

- Obesity and/or Weight Loss
- Conditions that have not been shown to be nutritionally related, including but not limited to Chronic Fatigue Syndrome and Hyperactivity.

OBESITY SURGERY

IMPORTANT: Prior Authorization is required.

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician provided either of the following is true:

- You have a minimum Body Mass Index (BMI) of 40.
- You have a minimum BMI of 35 with at least one complicating coexisting medical condition or disease present (such as sleep apnea or diabetes).

In addition to meeting the above criteria, the following must also be true:

- You have documentation from a Physician of a diagnosis of morbid obesity for a minimum of two years.
- You are age 18 or older or for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4.
- You have a 3-month Physician or other health care Provider supervised diet documented within the last 2 years.

- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation.
- The surgery is performed at a Bariatric Resource Service (BRS) Designated Provider by a Network surgeon even if there is no BRS Designated Provider near You.

Benefits are available for obesity surgery services provided that they are not Experimental, Investigational or Unproven Services.

Benefits are limited to one surgery per lifetime unless there are complications to the covered surgery.

You will have access to a certain Network of Designated Providers participating in the Bariatric Resource Services (BRS) program.

For obesity surgery services to be considered Covered Health Services under the BRS program, You must contact Bariatric Resource
Services and speak with a nurse consultant prior to receiving services. You can contact Bariatric Resource Services by calling 1-888936-7246.

If traveling more than 50 miles, You can receive obesity surgery services that are not performed as part of the Bariatric Resource Services program, the Plan pays Benefits as described under:

- Physician's Office Services
- Physician Fees for Surgical and Medical Services
- Lab, X-Ray and Diagnostic – Outpatient
- Lab, X-Ray and Major Diagnostics – Outpatient
- Outpatient Surgery, Diagnostic, and Therapeutic Services
- Hospital - Inpatient Stay
- Surgery - Outpatient
- Note: The services described under the Travel and Lodging are Covered Health Services only in connection with obesityrelated services received by a Designated Provider.

ORAL SURGERY

Charges for dental work, surgery, or orthodontic treatment needed to remove, repair, replace, restore, or reposition natural teeth or body tissues of the mouth that are fractured or cut due to an injury. If services are for a dental condition, Covered Health Services are not covered by the ACME Medical Plans – and instead apply to the Dental Plan.

ORAL SURGERY ANESTHESIA

Refer to “Dental Services (Surgery Anesthesia)”

ORTHOGNATHIC SURGERY

IMPORTANT: Prior Authorization is required.

Charges for surgery when the surgery is required for direct treatment of a skeletal anomaly of either the maxilla or mandible. The skeletal anomaly must cause a functional medical impairment such as one of the following: (a) inability to incise solid foods, (b) choking on incompletely masticated solid foods, (c) damage to soft tissue during mastication, (d) speech impediment determined to be due to the jaw deformity, or (e) malnutrition and weight loss due to inadequate intake secondary to the jaw deformity.

ORTHOTICS

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Service.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body. Implantable devices are a Covered Health Service for which benefits are available under the applicable medical/surgical Covered Health Service categories in this SPD.

Benefits do not include:

- Any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body. Implantable devices are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Service categories in this SPD.
- Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Service. Powered exoskeleton devices.

The Plan may also cover orthotics, including shoe orthotic and therapeutic molded shoe inserts, for adults when prescribed by a
Physician for treatment of severe systemic disease, such as for diabetes, or due to a severe injury. Coverage for flat feet is available if Medically Necessary and is supported by documentation by the Physician. New and replacement devices are limited to one every other Calendar Year or when required by a change to the prescription. Benefits are not provided for orthotics for routine care, such as for fallen arches or comfort.

Cranial orthotic devices are a reconstructive service for the treatment of craniofacial asymmetry in infants 3-18 months of age with

- severe nonsynostotic positional plagiocephaly
- craniosynostosis following surgical correction Severe plagiocephaly is defined as:
- an asymmetry of 10 mm or more in one of the following anthropometric measures: cranial vault, skull base, or orbitotragial depth; or
- a cephalic index at least two standard deviations above or below the mean for the appropriate gender/age.

Coverage is available when associated with a medical condition that is being treated by a Physician.

OSTOMY SUPPLIES

Benefits for Ostomy Supplies include the following:

- Pouches, face plates and belts
- Irrigation sleeves, bags and catheters
- Skin Barriers

OUTPATIENT PRE-ADMISSION TESTING

Covered Health Services related to Outpatient Laboratory and X-Rays (including review) - performed by a Hospital, Surgery Center, Licensed Diagnostic Lab, or Physician within seven days of a scheduled surgery.

OUTPATIENT SURGERY, DIAGNOSTIC, AND THERAPEUTIC SERVICES

Covered Health Services received on an Outpatient basis at a Hospital or Alternate Facility including:

- Surgery & Related Services
- Lab & Radiology/X-Ray
- Mammography Testing Sleep Studies
- Other diagnostic tests and therapeutic treatments (including Cancer Chemotherapy and Intravenous Infusion Therapy).

OUTPATIENT - LAB, X-RAY AND DIAGNOSTIC

IMPORTANT: Prior Authorization is required for Genetic Testing

Services for sickness and injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray
- Mammography

Benefits include:

- The facility charge and the charge for supplies and equipment
- Physician services for radiologists, anesthesiologists and pathologists (benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling
- Presumptive Drug Tests and Definitive Drug Tests- limited to 18 tests each per calendar year

Benefits for other Physician services are described in this section under Physician Fees for Surgical and Medical Services. Lab, X-ray and diagnostic services for preventive care are described under Preventive Care. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient.

OUTPATIENT - LAB, X-RAY AND MAJOR DIAGNOSTICS - CT, PET SCANS, MRI, MRA AND NUCLEAR MEDICINE

IMPORTANT: Prior Authorization is required for CT, PET SCANS, MRI, MRA, Nuclear Medicine, including nuclear cardiology and sleep studies.

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under Physician's Office Services - Sickness and Injury. Benefits for other Physician services are described in this section under Physician Fees for Surgical and Medical Services.

OUTPATIENT SURGERY

IMPORTANT: Prior Authorization is required for all outpatient surgeries, including blepharoplasty, cardiac catheterization, cochlear implants, uvulopalatopharyngoplasty, pacemaker insertion, vein procedures, spine surgery, total joint replacements, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery.

The Plan pays for Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include only the facility charge and the charge for supplies and equipment. Benefits for the surgeon fees and facility-based Physician's fees related to outpatient surgery are described under Physician Fees for Surgical and Medical Services.

When these services are performed in a Physician's office, Benefits are described under Physician's Office Services.

OUTPATIENT THERAPEUTIC

IMPORTANT: Prior Authorization is required.

The Plan pays for Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment. Benefits for facility-based Physician's fees related to these services are described under Physician Fees for Surgical and Medical Services.

When these services are performed in a Physician's office, benefits are described under Physician's Office Services.

PALLIATIVE CARE SERVICES

The Palliative Care benefit provides Covered Health Services under the Plan that seeks to prevent or relieve the physical and emotional distress produced by a life-threatening medical condition or its treatment. Services include covered benefits as stated in the Plan. For these purposes only and subject to the conditions in this Palliative Care Services section (and notwithstanding exclusions elsewhere in the Plan), Private Duty Nursing services are included. Private Duty Nursing services under a palliative care plan are covered if the skilled nursing services support life necessary functions. Functions may include, but are not limited to, ventilator support & respiratory surveillance, tracheostomy care, oxygen administration, deep oral suctioning and oral suctioning for persons who require external assistance in maintaining their airways, or other critical functions (such as managing unstable blood glucose or a complex feeding regimen). Skilled nursing facility care and/or sub-acute care may be covered if the above support is needed outside of the home setting.

To qualify for the Palliative Care benefit:

- UnitedHealthcare’s Care Coordination team must be contacted at least 5 working days in advance of services being provided; and
- A palliative care consult report and plan of care from an expert in the field (an expert in the field is a Physician who has been deemed board eligible or board certified in palliative care, or who has been designated as the palliative care expert at the facility in which he or she has hospital admitting privileges or has the designation at a teaching facility) must be submitted. The consultation can be obtained in person or virtually through electronic consultation from a documented palliative care program (adult or pediatric as appropriate for age and condition); and
- The Covered Person must be working with a Dedicated Nurse Advocate for long term follow-up.

Please note: Care Coordination must be notified within 10 working days of any change in the Covered Person’s status that may make the Covered Person no longer eligible for this benefit.

Consultation that has been provided electronically will be a Covered Health Service to the extent it otherwise qualifies under this Palliative Care Services provision.

A written palliative care plan must be submitted annually and continued eligibility for this benefit is subject to annual review by UnitedHealthcare.

If no palliative care program exists within 50 miles of the Covered Person's home, an electronic palliative consultation and plan from an established expert in the field will meet the requirement for a written palliative care plan.

Benefits are not available solely for the provision of custodial care. Non-skilled services that are provided in support of skilled services provided by a trained medical professional can be covered under the palliative care plan if they are deemed Medically Necessary. Benefits may be available for Covered Persons who are medically fragile, have complex care needs and may also need coordination of care.

Family members' roles and participation as care givers should be written in detail in the palliative care plan.

Respite care provided in a facility or in the home may be considered for up to 10 days per calendar year to address a family emergency or urgent family issue that requires that no family care giver is available.

PHYSICIAN FEES FOR SURGICAL AND MEDICAL SERVICES

Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing facility, Inpatient rehabilitation facility, Alternate Facility or for Physician house calls.
Covered Health Services provided by a non-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable deductible) as if those services were provided by a Network Provider; however Eligible Expenses will be determined as described in the definition of Eligible Expenses.

When these services are performed in a Physician's office, benefits are described under Physician's Office Services.

PHYSICIAN'S OFFICE SERVICES

Covered Health Services received in a Physician's office for the diagnosis and treatment of a sickness or injury. Services may be received in a Physician's freestanding office or an office located in a clinic or Hospital.

PREIMPLANTATION GENETIC TESTING

Preimplantation Genetic Testing (PGT-M and PGT-SR) and Related Services performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for Benefits the following must be met: PGT must be ordered by a Physician after Genetic Counseling.

- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).
- Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:
    - Ovulation induction (or controlled ovarian stimulation).
    - Egg retrieval, fertilization and embryo culture.
    - Embryo biopsy.
    - Embryo transfer.
    - Cryo-preservation and short-term embryo storage (less than one year).

Benefits are not available for long-term storage costs (greater than one year).

Benefit limits will be the same as, and combined with, those stated under Fertility.

Benefit limits for related services will be the same as, and combined with, those stated under Fertility. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder.

This limit includes Benefits for ovarian stimulation medications provided under the Prescription Drugs.

PRESCRIPTION DRUGS

Prescription drugs are available under medical plans on an Inpatient and Outpatient basis. The Plan will cover up to a 34-day supply for prescriptions filled at a retail pharmacy on an Outpatient basis. The Plan will cover up to a 90-day supply for Maintenance Prescriptions filled through the Plan's mail order option.

Prescription drugs that are classified Experimental, Investigational or Unproven, and not approved by the FDA are not covered. In addition, the Plan does not cover over-the-counter prescription medication. Refer to "Plan Exclusions" for more information on coverage limitations.

OptumRx

A Covered Person enrolled in one of the UnitedHealthcare Medical Plans obtains Prescription Drug coverage through OptumRx[8] - a United Health Group Company.

ID Card

A Covered Person's UnitedHealthcare ID card is used to access medical and pharmacy benefits. A Covered Person must show his or her ID card at a Network Pharmacy. The Covered Person's prescriptions will be covered based on the applicable UnitedHealthcare Medical Plan he or she is enrolled in.

Network & Non-Network Pharmacies

Network Retail Pharmacies: The Plan has a Network of participating retail pharmacies, which includes many large drug store chains.
Network pharmacies can be found at www.myuhc.com. You may also call the toll-free telephone number located on the back of Your ID card. To obtain Your Prescription from a retail pharmacy, simply present Your ID card and pay the applicable Plan cost (e.g., Copayment or Coinsurance).

Limiting Selection of Network Pharmacies: If OptumRx determines that You may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your choice of Network Pharmacies may be limited. If this happens, OptumRx may require You to choose one Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the chosen Network Pharmacy. If You don't make a choice within 31 days of the date OptumRx notifies You, OptumRx will choose a Network Pharmacy for You.

Non-Network Retail Pharmacies: With the exception of the UnitedHealthcare EPO and HPHC-Passport Plan, all UnitedHealthcare Medical Plans provide coverage for Prescriptions filled at a Non-Network Pharmacy. Prescriptions

[8] OptumRx is part of United Health Group's Optum Health Services platform. This platform focuses on helping improve the health care system itself, including population health management, care delivery and improving the clinical and operating elements of the system. OptumRx is dedicated to helping people achieve optimal health while maximizing cost savings by working closely with customers to create customized solutions to improve quality and safety, increase compliance and adherence, and reduce fraud and waste.

filled at a Non-Network Pharmacy are covered, however will cost more than a prescription filled at a Network Pharmacy. The UnitedHealthcare EPO and HPHC-Passport Plans do not cover Prescriptions filled at Non-Network Pharmacies. Prescriptions filled at a Non-Network Pharmacy will not be covered. You are responsible for 100% of the cost.

Refer to the Medical Plan Comparison Chart to view Plan coverage.

Prescriptions – Category Tiers

All Prescription Drugs covered by the Plan are categorized into one of three Tiers.

- Tier-1: lower cost; lower cost brand and generic are included
- Tier-2: mid-range cost; mix of brand and generic
- Tier-3: highest cost; mostly higher cost brand and select generic

Helpful Tips:

- Use Tier-1 Drugs for lower out of pocket costs
- Use Tier-2 Drugs instead of Tier-3 to reduce out of pocket costs
- Tier-3 Drugs have lower cost options in Tiers 1 & 2; ask your physician if they work

Preferred Drug List (PDL) and Tier Changes

The status of a Prescription Drug may move up or down a Tier. See below for more information:

- Medications may move to a lower tier at any time
- Medications may move to a higher tier when a generic becomes available
- Medications may move to a higher tier or be excluded from coverage most often on January 1 or July 1
- When a medication changes tiers, You may have to pay a different amount for that medication

Changes are based on the Prescription Drug List Management Committee's periodic Tier review decisions. When a Tier change is made to a medication You are prescribed, You may pay more or less for a Prescription Drug, depending on its new Tier assignment. Medications can move up or down a Tier so it is recommended that You review UnitedHealthcare's Prescription Drug List (PDL) throughout the year. You may access the PDL on www.myuhc.com. You may also view the PDL on the ACME US Benefits Website or contact UnitedHealthcare at the toll-free number located on the back of Your ID card for the most current information.

PDL Tier Factors

UnitedHealthcare's Prescription Drug List (PDL) Management Committee[9] makes the final approval of Prescription Drug placement in Tiers. In its evaluation of each Prescription Drug, the PDL Management Committee takes into account a number of factors including, but not limited to, clinical and economic factors. While the PDL Management Committee reviews both clinical and economic factors when assigning a Prescription Drug to a Tier, deciding whether a particular Prescription Drug is appropriate is a determination that is made by You and Your prescribing Physician.

PDL Tier Clinical Factors Include:

- Evaluations of the place in therapy
- Relative safety and efficacy
- Applicable supply limits or notification requirements PDL Tier Economic Factors Include:
- Acquisition cost of the Prescription Drug
- Available rebates
- Assessments on the cost effectiveness of the Prescription Drug

[9] Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

Rebates and Other Discounts

UnitedHealthcare and ACME may, at times, receive rebates for certain drugs included on the PDL, including those drugs that You purchase prior to meeting any applicable Deductible. As determined by UnitedHealthcare, the Plan may pass a portion of these rebates on to You. When rebates are passed on to You, they may be taken into account in determining Your Copayment and/or Coinsurance.

UnitedHealthcare and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this Outpatient Prescription Drug section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug section. UnitedHealthcare is not required to pass on to You, and does not pass on to You, such amounts.

Prescriptions – Plan Coverage

Each Prescription Drug Tier is assigned a cost (Copayment or Coinsurance) which is the amount You pay at a retail pharmacy, or the amount You pay if You have Maintenance Medications filled through the Plan's mail order program. Your Out-of-Pocket Prescription costs apply to the Plan's Deductible and Out-of-Pocket Maximum accumulators. The information following is a Plan coverage overview applicable to all UnitedHealthcare Medical Plans. Exceptions apply to the HSA Medical Plan. Refer to "Prescriptions - HSA Medical Plan" to review Plan coverage. For more information about Prescription coverage details for all Plans, refer to Medical Plan Comparison Chart.

Prescriptions – Summary of Coverage

- **Tier - 1** ○ Covered at 100% after Copayment
- **Tier - 2** ○ Covered at 100% after Coinsurance ○ Plan Deductible – Not Applicable ○ Assigned Out-of-Pocket Prescription cost "minimum" and "maximum" apply ○ Your cost will be no less than the assigned minimum ○ Your cost will not exceed the assigned maximum
- **Tier - 3** ○ Covered at 100% after Coinsurance ○ Plan Deductible – Not Applicable ○ Assigned Out-of-Pocket Prescription cost "minimum" and "maximum" apply ○ Your cost will be no less than the assigned minimum ○ Your cost will not exceed the assigned maximum
- **Specialty Medications** ○ Special fill requirements apply to Specialty Medications ○ Must be filled at a Specialty Pharmacy, Optum Specialty Pharmacy or other OptumRx designated Specialty pharmacy providers ○ 31 Day Supply Only

Prescription Fill Limits (Retail Pharmacy)

- Applies to all Plans and Tiers
- 34 Day Supply

Prescription Fill Limits (Mail Order)

- Applies to all Plans and Tiers
- 90 Day Supply

Prescription Fill Limit (Designated Pharmacies)

Smart Fill Program - Split Fill

Certain Specialty Prescription Drugs may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a prorated Copayment or Coinsurance. The Covered Person will receive a 15-day supply of his/her Specialty Prescription Drug to determine if he/she will tolerate the Specialty Prescription Drug prior to purchasing a full supply. The Designated Pharmacy will contact the Covered Person each time prior to dispensing the 15-day supply to confirm if the Covered Person is tolerating the Specialty Prescription Drug. You may find a list of Specialty Prescription Drugs included in the Smart Fill Program, through the internet at www.myuhc.com or by calling the telephone number on Your ID card.

Prescriptions - HSA Medical Plan

HSA Medical Plan – Preventive Medications

Eligible Preventive Medications are covered at 100% - free of charge.

HSA Medical Plan – Non-Preventive Medications

You are required to pay 100% of medication costs until the Deductible is satisfied. When the Deductible is satisfied, the Plan will pay a portion of the Eligible Expense. The Plan will pay a higher benefit when Prescriptions are filled at a Network Pharmacy.

Network Pharmacy

- Covered at 90% of Eligible Expense (Discounted Rate) – after Deductible is satisfied

Non-Network Pharmacy

- Covered at 70% of Eligible Expense (R&C) – after Deductible is satisfied
- Minimum cost amount – does not apply
- Maximum “Not to Exceed” – does not apply

Deductible and Out-of-Pocket Maximum

- Prescription charges apply to Your annual Deductible and Out-of-Pocket Maximum

Copayments are not applicable in the HSA Medical Plan

Prescriptions – Covered Health Services

Pharmacy benefits apply only if the prescription is for a Covered Health Service, and not for Experimental, Investigational or Unproven Services. Otherwise, the Covered Person is responsible for paying 100% of the cost. The Plan pays benefits for Prescription Drugs for a Covered Health Service:

- As Written By a Physician
- Up To a Consecutive 34-Day Supply
- ID Card Is Presented By Covered Person

Maintenance Medications

Individuals, who take Maintenance Medication(s), are encouraged to utilize OptumRx’s “Mail Service Member Select Program.” To verify if Your medication(s) qualifies as a Maintenance Medication, visit www.myuhc.com. You may also call the toll-free number located on the back of Your ID card.

Mail Service Member Select Program

The Mail Service Member Select Program encourages individuals to use the OptumRx Mail Service Pharmacy for medication(s) taken on a regular basis. This program allows a Covered Person to fill a 90-day supply of a covered Maintenance Medication through the Plan’s Mail Service Member Select Program. To utilize the Mail Service Member Select Program, the Covered Person must complete a patient profile and enclose a Prescription order or refill. The medication, including instructions for obtaining refills, will arrive by mail about 14 days after the order is received. There is no charge for shipping/mailing – and the Plan pays mail order benefits for covered Maintenance Medications:

- as written by a Physician; and

- up to a consecutive 90-day supply

Maintenance Medications (Action Required)
Choosing home delivery helps You manage Your Maintenance Medication(s), saves time, and money. The Plan requires You to confirm enrollment in the Mail Service Member Select Program or opt-out and fill Maintenance Medication(s) at a retail pharmacy. The Plan allows a "grace period" of two fills at a retail pharmacy. If You do not "Enroll" or "Dis-Enroll" prior to Your third fill, You may have to pay 100% of the medication's retail cost until You take action.

Action Required: Prior to Your third medication fill, You MUST complete the following:

- Enroll in the Mail Service Member Select Program; or
- opt-out from the Mail Service Member Select Program and continue filling Maintenance Medication(s) at a Network retail pharmacy

Be reminded, if You do not "Enroll" or "Dis-Enroll" prior to Your third medication fill, You may have to pay 100% of the medication's retail cost until You take action.

Enroll and Dis-Enroll Instructions:

To ENROLL in Mail Service Member Select

1. Access www.myuhc.com
2. Go to > Manage My Prescriptions
3. Then to > Savings Center or click on the medication in your dashboard you want to transfer to home delivery and follow transfer instructions Or To ENROLL via the app:
1. Go to the UHC app
2. Click on the Rx icon at the bottom of the screen
3. Go to 'current medications" or "refills and home delivery" tab to transfer medication to home delivery

Or To ENROLL via the phone call UnitedHealthcare at the toll-free number located on the back of Your ID card.

To DIS-ENROLL, call UnitedHealthcare at the toll-free number located on the back of Your ID card.

Specialty Medications
Rare or complex conditions may require appropriate use of Specialty Medications and can be critical to maintaining or improving the health of the Covered Person. The Specialty Pharmacy Program provides the resources and personalized condition-specific support needed to help the Covered Person better manage the condition. For assistance, contact the Specialty Pharmacy Referral Line: 1-888702-8423 (24 hours a day, 7 days a week). Medications are generally classified as a "Specialty Medication" if the medication meets the following criteria:

- is an injectable, an oral, or an inhaled medication; and
- is used to treat a chronic or complex condition; and
- requires extra, ongoing clinical oversight, and additional education for best management; and
- has unique storage or shipping requirements; and
- is typically not available at retail pharmacies; and
- is expensive - the average cost for 30-day supply is $2,500+
- Designated Specialty Medications are marked as "DSP" in the UnitedHealthcare Preferred Drug List

Specialty Medication - Examples

Specialty Medications are used to treat rare, unusual, or complex medical conditions including, but are not limited to the medications included in the table below. Self- administered diabetes products are not classified as a Specialty Medication.

Allergic Asthma	Immune Deficiency
Anemia	Fertility
Arthritis	Multiple Sclerosis
Cancer	Cystic Fibrosis
Endocrine Disorder	Osteoporosis
Enzyme Deficiency	Parkinson's Disease
Excess Iron	Psoriasis
Growth Hormone Deficiency	Pulmonary Arterial Hypertension
Hemophilia	Respiratory Syncytial Virus
Hepatitis B	Thrombocytopenia
Hepatitis C	Transplant
HIV/AIDS	Vaccines

Specialty Medications – Fill Instructions

A Covered Person must use a designated OptumRx Specialty Pharmacy to fill all prescribed Specialty Medication(s) beginning with the first fill. A grace period allowing a Covered Person to fill the initial Specialty Medication fill at a retail pharmacy is not permitted. If a medication is identified as a Specialty Medication – it must be filled through mail order by a designated OptumRx Specialty Pharmacy, Optum Specialty Pharmacy or another designated Specialty Pharmacy in the OptumRx Specialty Network. Specialty Medications not filled by a designated OptumRx Specialty Pharmacy, including Network OptumRx Retail Pharmacies, will NOT be covered by the Plan. If Specialty Medications are filled by a non-designated OptumRx Specialty Pharmacy, benefits are NOT paid and You are responsible for 100% of the actual medication cost.

Specialty Medications – Purpose and Benefits

The Specialty Pharmacy Program is designed to make Specialty Medications accessible and cost effective. The program provides focused support to help manage rare and complex conditions by offering:

- **Better Use of Benefits**: Maximize health benefits by getting the right Specialty Medications from Network Providers when needed
- Specialty Pharmacies & Home Health Care Providers: Network Providers have the resources and expertise needed to store and dispense Specialty Medications and ancillary supplies
- **Expert Support**: 24/7 telephone access to specially trained pharmacists who can provide answers, patient education materials, proactive refill monitoring, counseling on side effects and more
- **Individualized Services**: Experienced nurses and pharmacists trained in Specialty Medications and rare and complex conditions offer personalized therapy support that can lead to better health outcomes

Variable Copayment Program

Certain Specialty Medications are eligible for Copayment assistance by drug manufacturers. OptumRx may help You determine whether Your Specialty Medication is eligible for Copayment assistance. If You receive Copayment assistance from a drug manufacturer, Your Copayment and/or Coinsurance may vary. Please contact OptumRx at www.myuhc.com or the telephone number on Your ID card for a list of Specialty Medications available in this program. If You choose not to participate, You will pay the applicable Copayments and/or Coinsurance requirements.

Amounts paid by drug manufacturers toward cost sharing will not count toward any deductible that applies or out-of-pocket limit.

Prior Authorization Requirements

Before certain Prescription Drugs are dispensed to You, it is the responsibility of Your Physician, Your pharmacist or You to obtain
Prior Authorization from UnitedHealthcare. UnitedHealthcare will determine if the Prescription Drug, in accordance with UnitedHealthcare's approved guidelines, is both:

- a Covered Health Service as defined by the Plan; and
- not Experimental, Investigational or Unproven; and
- prescribed by a Physician

The Plan may also require You to obtain Prior Authorization from UnitedHealthcare so UnitedHealthcare can determine whether the Prescription Drug, in accordance with its approved guidelines, was prescribed by a Specialist Physician.

Prescription Drugs requiring Prior Authorization review may be required due to, but not limited to the following:

- Cost more than other medications used to treat the same or similar conditions
- Be a Compound Medication with a cost greater than $250
- Be prescribed for conditions for which their safety and effectiveness have not been proven
- Medications requiring Prior Authorization are marked "PA" in the UnitedHealthcare Preferred Drug List

Network Pharmacy Prior Authorization

When Prescription Drugs are dispensed at a Network Pharmacy, the prescribing Provider, the pharmacist, or You are responsible for obtaining Prior Authorization from UnitedHealthcare.

Non-Network Pharmacy Prior Authorization

When Prescription Drugs are dispensed at a Non-Network Pharmacy, You or Your Physician are responsible for obtaining Prior Authorization from UnitedHealthcare as required.

If UnitedHealthcare has not provided Prior Authorization before the Prescription Drug is dispensed, You may pay more for that Prescription Drug order or refill. You will be required to pay for the Prescription Drug at the time of purchase. The contracted pharmacy reimbursement rates (the Prescription Drug Charge) will not be available to You at a Non-Network Pharmacy. If
UnitedHealthcare has not provided Prior Authorization before You purchase the Prescription Drug, You can request reimbursement after You receive the Prescription Drug.

When You submit a claim on this basis, You may pay more because You did not obtain Prior Authorization from the UnitedHealthcare before the Prescription Drug was dispensed. The amount You are reimbursed will be based on the Prescription Drug Charge (for Prescription Drugs from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drugs from a NonNetwork Pharmacy), less the required Copayment and/or Coinsurance and any Deductible that applies.

To determine if a Prescription Drug requires Prior Authorization, either visit www.myuhc.com or call the toll-free number on Your ID card. The Prescription Drugs requiring Prior Authorization are subject to the UnitedHealthcare's periodic review and modification.

Benefits may not be available for the Prescription Drug after UnitedHealthcare reviews the documentation provided and determines that the Prescription Drug is not a Covered Health Service or it is an Experimental, Investigational or Unproven Service.

UnitedHealthcare may also require Prior Authorization programs that may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable Prior Authorization, participation, or activation requirements associated with such programs through the Internet at www.myuhc.com or by calling the toll-free number on Your ID card.

Prior Authorization Instructions

Certain Prescription Drug classifications, including anti-fungal, miscellaneous skin conditions, and testosterone replacement, require You or Your Physician to submit an online Prior Authorization request. To initiate the Prior Authorization, Your Physician is required to access one of the websites listed in the table below. The website Your Physician should use is based on his or her Provider Network status. If Your treatment includes a medication requiring Prior Authorization, be sure to share the applicable website address and instructions with Your Physician.

Provider Network Status	Prior Authorization
Network Providers	www.optumrx.com
Non-Network Providers	www.covermymeds.com/epa/optumrx/

If Your Physician or Pharmacist chooses to use the online website, he or she should proceed through the step-by-step instructions.

1. Access the applicable "OPTUMRX" website
2. Then, follow the navigation path > HEALTHCARE PROFESSIONALS > PRIOR AUTHORIZATIONS
3. Next, follow the online instructions to complete the Prior Authorization request
4. When all information is entered, submit the online request
5. Upon receipt of the request, OptumRx will review the Prior Authorization to determine if the medication is a Covered Health Service
6. When OptumRx completes the review process, a letter of determination will be mailed to You and Your Physician
7. You may contact OptumRx or UnitedHealthcare at the toll-free phone number located on Your ID card, approximately 24-48 hours following Your Physician's submission to check the status of the review.
8. If Your medication IS APPROVED, the medication may be filled in accordance with the Plan's Prescription Drug coverage
9. If the medication IS NOT APPROVED, You and Your Physician may consider the following next steps: ○ Discuss alternative treatment options and decide if a different treatment solution is available (recommended option); or
   - ○ appeal the decision – refer to "Appealing a Denied Claim"; or ○ fill the medication without approval.

IMPORTANT: IF YOUR PHYSICIAN DOES NOT OBTAIN PRIOR AUTHORIZATION, YOUR MEDICATION FILL MAY BE DELAYED OR DECLINED. ADDITIONALLY, BENEFITS WILL NOT BE PAID AND YOU WILL BE RESPONSIBLE FOR 100% OF THE MEDICATION'S RETAIL COST.

PREVENTIVE CARE

Regular Preventive Care visits and health screenings help You learn Your current health status and may help identify potential health issues before they become more serious. Covered Preventive Care services include physical examinations, Immunizations, laboratory tests, and other screenings. If You need assistance identifying the exams, Immunizations, and screenings You may be due for, call UnitedHealthcare using the toll-free number located on the back of Your ID card. You may also visit www.uhcpreventivecare.com to view a list of Preventive Care guidelines.

The Plan follows the following United States Preventive Care guidelines:

- Preventive service "A" and "B" recommendations of the U.S. Preventive Services Task Force (USPSTF)
- Immunizations recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunization
- Practices (ACIP) and recommendations by the Health Resources and Services Administration (HRSA)
- Pediatric services based on guidelines supported by the HRSA, including recommendations by the American Academy of Pediatrics Bright Future pediatric schedule, and newborn metabolic screenings
- Preventive care and screening for women as provided in the comprehensive guidelines supported by the HRSA.

Network Preventive Care

Certain Preventive Care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), at no cost to You, provided care is received by a Network Provider. These Preventive Care services are based on age, gender, and other health factors. Other routine services may require a Copayment, Coinsurance, or Deductible. Treatment due to a symptom or an existing illness, and laboratory tests, or other health screenings, necessary to manage or treat an already-identified medical issue or health condition, are usually not considered or covered as Preventive Care.

Preventive Care Services (Adults)

As recommended by the U.S. Preventive Services Task Force, the types of services covered as Preventive Care services for adults include but are not limited to the following services that have a current rating of A or B:

- Adult Routine Physical Exams
- Routine Screenings Such As Blood Pressure, Cholesterol, Diabetes
- Routine Screenings Such As Mammography, Colonoscopy, Pap Smear
- Routine Gynecological Exams
- Bone Density Tests
- Routine Prenatal Care And Exams
- Screening For Depression And Obesity

- Smoking Cessation Counseling

Preventive Care Services (Women)

Under the Patient Protection and Affordable Care Act (ACA), women's Preventive Care includes services such as mammograms, screenings for cervical cancer, and prenatal care. In addition, an expanded list of Preventive Care services designed specifically for women has been developed to ensure the unique health needs of women throughout their lifespan are addressed. Preventive Care services for women include, but are not limited to:

- Well-Women Visits (including pre-pregnancy, prenatal, postpartum, and interpregnancy visits)
- Screening For Gestational Diabetes
- Human Papillomavirus Testing
- Counseling For Sexually Transmitted Infections
- Counseling and Screening For Human Immunodeficiency Virus
- All Food and Drug Administration Approved Contraceptive Methods and Counseling
- Breastfeeding Support, Equipment, Supplies, and Counseling
- Screening and Counseling For Interpersonal and Domestic Violence
- Counseling to Prevent Obesity in Midlife (Age 40-60) Women

Preventive Care Services (Children)

As recommended under the Bright Futures guidelines, developed by the Health Resources and Services Administration with the
American Academy of Pediatrics, the types of services for Children covered as Preventive Care services include, but are not limited to:

- Well-Baby Care Physical Exams
- Well-Child Care Physical Exams
- Vision and Hearing Screenings
- Developmental Assessments
- Screening For Depression and Obesity
- Routine Vaccines

As recommended by the Center for Disease Control's Advisory Committee on Immunization Practices, the types of routine vaccines covered as Preventive Care services include but are not limited to routine Childhood Immunizations including: Diphtheria

- Tetanus
- Pertussis
- Polio
- Chicken Pox
- Measles
- Mumps
- Rubella
- Hepatitis A & B
- Pneumococcal
- Meningococcal
- Rotavirus
- Human Papillomavirus
- Flu

PRIVATE DUTY NURSING

IMPORTANT: Prior Authorization is required.

Care of Covered Person (in Covered Person's home). Care is provided by a licensed nurse and must be ordered by a Physician. Custodial Care is not covered.

PROSTHETIC DEVICES

IMPORTANT: Prior Authorization is required when cost exceeds $1,000. That replace a limb or body part including:

- Artificial arms, legs, feet and hands
- Artificial face, eyes, ears and noses

- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet Your functional needs, benefits are available only for the prosthetic device that meets the minimum specifications for Your needs. The prosthetic device must be ordered or provided by, or under the direction of a Physician. If You purchase a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and You may be responsible for paying any difference in cost. The Plan provided benefits for a single purchase, including repairs, of a type of prosthetic device. Benefits are provided for the replacement of each type of prosthetic device every three Calendar Years (or more frequently as Medically Necessary due to growth for a child under the age of 19). At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe (e.g., a child's normal growth).

Benefits are available for repairs and replacement, except that:

- There are no benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

RADIOLOGIST, ANESTHESIOLOGIST AND PATHOLOGIST SERVICES (RAPS)

Laboratory/X-ray Expenses, Outpatient Surgery, Diagnostic and Therapeutic Services

Services rendered by a Radiologist, Anesthesiologist, Pathologist or Laboratory (RAPL) in a Network facility setting (Inpatient Hospital,
Outpatient Hospital, Ambulatory Surgical Center) will be reimbursed at the Network benefit level, regardless of the RAPL Provider's Network or Non-Network status. Preadmission testing is included. Network benefits will also be paid for these Covered Health Services at a Non-Network facility if the prescribing Physician is a Network Provider.

RECONSTRUCTIVE PROCEDURES

IMPORTANT: Prior Authorization is required.

Services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. By improving or restoring physiologic function, it is meant that the target organ or body part is made to work better. An example of a reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Cosmetic Procedures

Services are considered cosmetic procedures when they improve appearance without making an organ or body part work better. The fact that a person may suffer psychological consequences from the impairment does not classify surgery and other procedures done to relieve such consequences as a reconstructive procedure. Reshaping a nose with a prominent "bump" would be a good example of a Cosmetic Procedure because appearance would be improved, but there would be no effect on function like breathing. This Plan does not provide benefits for cosmetic procedures.

Reconstructive

IMPORTANT: Prior Authorization is required.

Some services are considered cosmetic in some circumstances and reconstructive in others. This means that there may be situations in which the primary purpose of the service is to make a body part work better, whereas in other situations, the purpose would be to improve appearance and function (such as vision) is not affected. A good example is upper eyelid surgery. At times, this procedure will improve vision, while on other occasions improvement in appearance is the primary purpose of the procedure.

Please note that benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Other services mandated by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any Covered Health Service.

REHABILITATION SERVICES AND HABILITATIVE SERVICES

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services limited to for the following types of therapy: Physical therapy.

- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Vision therapy.
- Cognitive rehabilitation therapy following a post-traumatic brain injury or cerebral vascular accident.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.

For all rehabilitation services, a licensed therapy Provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits under this section are not available for maintenance/preventive treatment.

For outpatient rehabilitation services for speech therapy, the Plan will pay benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from injury, stroke, cancer, Congenital Anomaly, autism spectrum and/or development delay. Stuttering is a covered diagnosis under speech therapy in association with development delay disorder.

Therapies related to development delay are also considered a Covered Health Service. Services must be rendered by a licensed Provider.

Habilitative Services

For the purpose of this benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed Provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

UnitedHealthcare will determine if benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.
- The initial or continued treatment must be proven and not Experimental, Investigational or Unproven.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating Provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under Durable Medical Equipment and Prosthetic Devices.

Benefits are limited to:

- 60 visits per calendar year for physical therapy.
- 60 visits per calendar year for occupational therapy.
- 60 visits per calendar year for speech therapy.
- 20 visits per calendar year for Spinal Manipulation.

These visit limits apply to Network Benefits and Non-Network benefits combined.

NOTE: Additional visits above the Calendar Year limit require clinical review and approval.

ROUTINE PHYSICAL EXAMS

Refer to "Preventive Care Services"

SKILLED NURSING FACILITY/INPATIENT REHABILITATION FACILITY

IMPORTANT: Prior Authorization is required.

Services for an Inpatient stay. Benefits are available for:

- Services and supplies received during the Inpatient stay.
- Room and board in a Semi-private Room (a room with two or more beds).

Benefits are limited to 100 days per Calendar Year. Additional visits above the Calendar Year limit require clinical review and approval.

In general, the intent of Skilled Nursing is to provide benefits for individuals who are convalescing from an injury or illness that requires an intensity of care or a combination of Skilled Nursing, rehabilitation and facility services which are less than those of a general acute Hospital but greater than those available in the home setting. The individual is expected to improve to a predictable level of recovery.

Benefits are available when Skilled Nursing and/or rehabilitation services are needed on a daily basis. Accordingly, benefits are NOT available when these services are required intermittently (such as physical therapy three times a week).

Benefits are NOT available for custodial, domiciliary or maintenance care (including administration of enteral feeds) which, even if it is ordered by a Physician, is primarily for the purpose of meeting personal needs of the individual or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence. (Custodial, domiciliary or maintenance care may be provided by persons without special skill or training. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs.)

SPINAL MANIPULATION (CHIROPRACTOR)

Charges for the diagnosis and treatment of misalignment, dislocation, biochemical, or nerve disorder of the spine and strained muscles or ligaments related to a spinal disorder.

The Plans will cover both maintenance and non-maintenance related services up to the maximum number of visits specified in the Medical Plan Comparison Chart. If You reach the maximum number of visits specified in the Medical Plan Comparison Chart, additional benefits for the Calendar Year will only be available if the treatment and/or services are Covered Health Services and not maintenance related. Maintenance related therapy and/or a service is a treatment or therapy designed to provide for the patient's continued well-being, or for maintaining the optimum state of health, while minimizing recurrence of the clinical status. This means that it is not clearly indicated from Your Physician's notes that a medical condition exists for which spinal manipulation is a proven treatment, and services rendered will not be covered beyond the yearly maximum benefit identified in the Medical Plan Comparison Chart.

To be eligible for these additional benefits, Your Provider must submit chart notes or progress reports to UnitedHealthcare for review. If UnitedHealthcare determines the treatment and/or services are appropriate, and progress is being made, additional benefits will be made available. UnitedHealthcare will continue to request chart notes periodically to ensure the additional treatment and/or services continue to be appropriate and Covered Health Services. During any subsequent reviews made by UnitedHealthcare, no claims incurred will be covered until UnitedHealthcare completes their review and determines continued coverage may be made available.

Refer to the Medical Plan Comparison Chart for coverage levels and maximums for each Plan.

SPINE AND JOINT SURGERIES

Benefits for spine and joint surgeries which are ordered by a Physician. Spine and joint surgical procedures include the following:

- Spine fusion surgery
- Spine disc surgery
- Total knee replacement
- Total hip replacement

Designated Network benefits include Physician fees, the facility charge and the charge for supplies and equipment. Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under Physician's Office Services.

TELEHEALTH (TELEMEDICINE)

Covered Health Services which provide the Covered Person with the ability to contact a Network Provider or Non-Network Provider rather than visiting the Provider in person.

The Provider must have the ability to support and bill for the digital service.

Telehealth through AmWell

Covered telehealth through ACME's third party telehealth administrator, AmericanWell (AmWell), includes general Physician,
Specialties, Nutritional Counseling, Mental Health Counseling, and Breastfeeding Counseling (for coverage level see the comparison chart).

Covered Health Services include the diagnosis and treatment of low acuity medical conditions using interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Services provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work). Network benefits are available only when services are delivered through AmericanWell (AmWell).

Please Note: Not all medical conditions can be appropriately treated through AmWell. The AmericanWell (AmWell) Physician or health care specialist will identify any condition for which treatment by in-person Physician or health care specialist contact is necessary. Benefits under this section do not include email, or fax and standard telephone calls, or for telehealth through nonAmWell Providers.

Telehealth as an alternative to in person visits

Telehealth services as an alternative to in person healthcare office visits are a Covered Health Service for Covered Persons. Telehealth services provide the Covered Person with the ability to contact their own choice of Network Provider or Non-Network Provider rather than going through AmWell or going into a Provider's office. The Provider must have the ability to support and bill for the digital service. Services are covered the same as in office visits (for coverage level see the comparison chart).

Telehealth Providers include:

- Physicians
- Nurse practitioners

- Physician assistants
- Nurse-midwifes
- Clinical nurse specialists
- Registered dietitians or nutrition professionals
- Clinical social workers
- Certified Registered Nurse Anesthetists
- Speech Therapists
- Occupational Therapists
- Physical therapists
- Clinical psychologist/Behavioral Health)

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

Expenses for appliances are not covered under the Plan. Appliances are covered under the Dental Plans and not by the UnitedHealthcare Medical Plans.

The Plan covers services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.
Diagnosis: Examination, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including clinical examinations, arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations.

Benefits for surgical services also include FDA-approved TMJ prosthetic replacements when all other treatment has failed.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in *Hospital* and *Physician Fees for Surgical and Medical Services*, respectively.

TRANSPLANT SERVICES

IMPORTANT: Prior Authorization is required.
Organ and tissue transplants, including CAR-T cell therapy for malignancies, when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not Experimental, Investigational or Unproven.

Examples of transplants for which benefits are available include bone marrow, including CAR-T cell therapy for malignancies, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which benefits are payable through the organ recipient's coverage under the Plan.

UnitedHealthcare has specific guidelines regarding benefits for transplant services. Contact UnitedHealthcare at the number on Your ID card for information about these guidelines.

Transplant services including evaluation for transplant, organ procurement and donor searches and transplant procedures may be received at a Designated Provider, Network facility that is not a Designated Provider or a non-Network facility.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from UnitedHealthcare for a cornea transplant nor is the cornea transplant required to be performed at a Designated Provider.

Note: The services described under Travel and Lodging are Covered Health Services only in connection with transplant services received at a Designated Provider.

Prior Authorization – Required

IMPORTANT: Prior Authorization is required for all transplant Covered Health Services

- If Prior Authorization is not attained – Plan benefits will be reduced or not paid
- Network Providers ARE RESPONSIBLE for Prior Authorization
- Non-Network Providers ARE NOT RESPONSIBLE for Prior Authorization. The responsibility rests on the Covered Person receiving transplant services from a Non-Network Provider
- A Covered Person receiving transplant services from Non-Network providers MUST contact UnitedHealthcare and request Prior Authorization. This action should occur as soon as the possibility of a transplant arises – and no later than the pretransplantation evaluation is performed.

The Plan has specific guidelines regarding transplant Covered Health Services. Contact United Resource Networks at (888) 936-7246 or the telephone number on Your ID card for information about these guidelines.

TRAVEL AND LODGING

Assistance with travel and lodging (meals are excluded) expenses for the Covered Person and a companion are available under this Plan when:

- Associated with any Covered Health Service
- Covered Person is not covered by Medicare
- There is no Network Provider for the Covered Health Service within 50 miles of the Covered Person's home address or if the Covered Health Service is performed at a Designated Provider, the Covered Person lives more than 50 miles away from the Designated Provider
- Maximum lifetime limit of $10,000 (excluding Mental Health Services and Substance-Related and Addictive Disorders Services)
- UnitedHealthcare must receive valid receipts for such charges before You will be reimbursed.

Travel and Lodging – Plan Benefits

Covered travel and lodging benefits include:

- Transportation of the Covered Person and one companion (airfare at economy or coach rate) who is traveling on the same day(s) to and/or from the site of the Covered Health Service provided by a Provider for the purposes of an evaluation, the procedure, or necessary post-discharge follow-up
- Covered lodging expenses for the Covered Person and one companion ○ Benefits are paid at a per diem (per day) rate up to $50 per day for the companion while the

Covered Person (patient) is Inpatient at the hospital; or ○ Up to $50 per day for the Covered Person and $100 per day for the Covered Person plus one companion; or

○ When the Covered Person is an enrolled Dependent minor Child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $100 per day.

URINARY CATHETERS

Covered Health Services include external, indwelling and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit)
- Anchoring device
- Irrigation tubing set

URGENT CARE SERVICES

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, benefits are available as described under Physician's Office Services.

WELL-BABY/WELL-CHILD ROUTINE EXAMS

Coverage for charges made by a Physician associated with routine Physician visits for Children up to the recommended ages – see Preventive Care. Coverage includes Child Immunizations, Hepatitis B, and tuberculosis testing. Well-baby care is an Outpatient benefit only. Covered Immunizations are established by the American Pediatric Association.

WIGS

Coverage is available for wigs prescribed by a Physician when the hair loss is the result of a medical condition (such as chemotherapy and radiation treatment for cancer). The benefit for wigs is limited to a maximum of $500 of billed charges per diagnosis, regardless of the network status of the Provider. Please note that Network Deductibles and Coinsurance apply to a Non-Network Provider when a Network Provider is not available.

X-RAY AND LAB SERVICES/X-RAY, RADIUM AND RADIOACTIVE ISOTOPE THERAPY

For Inpatient and Outpatient Care provided by a Hospital, licensed facility, Outpatient facility, or Physician's office. Coverage includes X-Ray and Lab tests, services, and materials (including but not limited to therapeutic X-rays and isotopes, electrocardiograms, UV light therapy and radium therapy).

Plan Exclusions – What Is Not Covered

The Plan Exclusions are categorized and listed within key categories. The categories in this section do not create, define, modify, limit, or, expand Plan Exclusions. These Exclusions apply to all Covered Persons.

The Plan will **not** pay or approve benefits for any of the services, treatments, supplies, or other items described in this section, even if one or both of the following is true:

- It is recommended or prescribed by a Provider (Network and Non-Network); and - It is the only available treatment for Your condition

The services, treatments, supplies, and other items described in this section "Plan Exclusions – What is Not Covered" are not Covered Health Services of ACME's UnitedHealthcare Medical Plans. The ACME UnitedHealthcare Medical Plans will not pay or approve benefits that are not Covered Health Services.

ALTERNATIVE TREATMENTS

- Acupuncture treatment or therapy designed to provide the Covered Person continued well-being, or maintain the optimum state of health, while minimizing recurrence of the clinical status. Acupuncture treatment to address chronic pain, disease, or injury is a Covered Health Services. For more information, refer to Acupuncture in Covered Health Services.
- Acupressure
- Aromatherapy
- Christian Science Provider
- Controlled Substances (Non-FDA Approved)
- Holistic or Homeopathic Care
- Hypnotism
- Marijuana used for recreational use
- Marijuana used for medical use - even if allowed by state law and used to treat a diagnosed medical condition
- Massage Therapy
- Rolfing
- Services Received By a Naturopath
- Wilderness, adventure, camping, outdoor and other similar programs
- Other Forms of Alternative Treatment As Defined By the Office of Alternative Medicine of The National Institutes of Health

AUTISM SPECTRUM DISORDER

Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental, Investigational or Unproven Services and are not Covered Health Services.

Exclusions – Autism Spectrum Disorder

- Nutritional Supplements
- Services and Programs provided in a school setting
- Tuition for Services and Programs provided in a school setting
- Services Performed By a Non-Authorized or Non-Qualified Provider
- Supplies or Equipment Associated with Treatments
- Therapies and Modalities ○ Cleansing Therapy ○ Dolphin Therapy ○ ECT Therapy ○ Floortime Approach/Therapy ○ Music Therapy
  - ○ Relationship Development Intervention (RDI)

COMFORT AND CONVENIENCE

- Beauty and barber services
- Devices and computers to assist in communications and speech, except for speech aid devices and tracheoesophageal voice devices
- Telephone or Television
- Remodel home to accommodate a medical need. Exclusions include, but are not limited to: ○ Ramps

○ Swimming Pool ○ Safety Bars

- Incidental Services, Supplies, and Equipment For Personal Comfort ○ Air Conditioners ○ Air Purifiers and Filters ○ Batteries and Battery Chargers ○ Humidifiers and Dehumidifiers

DENTAL EXCLUSIONS

The information represented in this section reflects the dental-related services excluded from the ACME UnitedHealthcare Medical
Plans. Generally, non-accidental dental related services are not Covered Health Services of the ACME UnitedHealthcare Medical Plans - except as described in "Covered Health Services."

ACME's self-insured Dental Plans (administered by MetLife) provide comprehensive dental coverage - including orthodontia. Please refer to "Covered Health Services" for more information.

Dental Exclusions (ACME's UnitedHealthcare Medical Plans)

Dental services not covered by the ACME UnitedHealthcare Medical Plans:

- Preventive, diagnostic, and treatment of the teeth, jawbones, or gums
- Extraction, restoration, and replacement of teeth
- Medical or surgical treatment for a dental-related condition
- Services to improve the clinical outcome of dental-related condition
- Dental Implants are not a Covered Health Service, unless the dental implant(s) is the result of an accidental dental injury Orthodontia Services ("Braces") are not a Covered Health Service, unless:
  ○ Braces are required for the direct treatment of an acute traumatic injury or cancer; or ○ braces are an integral part of reconstructive surgery for cleft palate[10] procedures
- Treatment of congenitally missing, malposed, or super numerary of teeth[12] even if related to a Congenital Anomaly
- Oral Devices (including night guard), except for treatment of sleep apnea in accordance with UnitedHealthcare Medical Guidelines
- **Dental appliances, hospitalization (including associated expenses), supplies, and x-rays, are not Covered Health Services, unless services are required to**: (Dental Service -Surgery Anesthesia See) ○ Cleft Palate Reconstructive Surgery ○ Initiation of Immunosuppressive Therapy ○ Preparation of Organ Transplant ○ Treatment of Acute Traumatic Injury ○ Treatment of Cancer

DRUGS

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drugs section of this document. See Prescription Drugs section and Plan Exclusions – Prescription Drugs for coverage and exclusion details.

- Prescription Drugs for outpatient use that are filled by a prescription order or refill.

[10] Cleft palate is an opening in the roof of the mouth due to a failure of the palatal shelves to come fully together from either side of the mouth and fuse during the first months of development as an embryo. Dental braces are a Covered Health Service if Orthodontic services are an integral part of reconstructive surgery for Cleft Palate [12] Super numerary of teeth is a duplication of teeth in the normal series and is found at the end of a tooth series.

- Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified Provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to certain hemophilia treatment centers that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to Covered Persons for self-administration.
- Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
- Over-the-counter drugs and treatments.
- Growth hormone therapy.
- Certain new Pharmaceutical Products and/or new dosage forms until the date as determined by UnitedHealthcare or UnitedHealthcare's designee, but no later than December 31st of the following calendar year.
- This exclusion does not apply if You have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment). If You have a life-threatening sickness or condition, under such circumstances, Benefits may be available for the new Pharmaceutical Product to the extent provided for in the definition of Experimental, Investigational or Unproven Services.
- A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
- A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
- Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.
- Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by UnitedHealthcare. Such determinations may be made up to six times during a calendar year.
- Certain Pharmaceutical Products that have not been prescribed by a Specialist
- Compound drugs that contain certain bulk chemicals, Compound drugs that are available as a similar commercially available Pharmaceutical Product

DURABLE MEDICAL EQUIPMENT (DME)

- If Your functional needs can be met by more than one Durable Medical Equipment device - benefits are available for the most cost- effective device only.
- The Plan does not cover the charge for more than one DME device that offers the same or similar purpose.
- Devices and computers to assist in communication and speech except for dedicated speech generating devices and tracheoesophageal voice devices for which benefits are provided as described under Durable Medical Equipment (DME) or Orthotics under Covered Health Services section.

EXPERIMENTAL, INVESTIGATIONAL OR UNPROVEN SERVICES

Experimental, Investigational or Unproven Services are excluded – even when the Experimental, Investigational or Unproven Services is the only available treatment for a particular condition.

FOOT CARE

- Routine foot care services that are not covered include cutting or removal of corns and calluses; nail trimming or cutting; and debriding (removal of dead skin or underlying tissue).
- Hygienic and preventative maintenance including cleaning and soaking feet, applying skin creams in order to maintain skin tone and any other service not performed to treat a localized illness, injury, or symptom involving the foot.
- Treatment of subluxation (joint or bone dislocation) of the foot shoe or shoe orthotics not prescribed by Physician.

GENDER DYSPHORIA

The following treatments relating to gender dysphoria are excluded:

- Cosmetic procedures, including the following:
- Abdominoplasty
- Lipofilling
- Liposuction
- Excision of excessive skin and subcutaneous tissue
- Implants (calf, gluteal, hip, pectoral)
- Monsplasty or Mons reduction (except as may be necessary as a part of genital reconstructive surgery)
  - Skin resurfacing (dermabrasion, chemical peel)
- Mastopexy
- Body contouring, such as lipoplasty
- Penile Transplant
- Uterine Transplant
- Reversions of prior gender affirming surgeries in the absence of medical complications.

Note: Covered Health Services provided to treat gender dysphoria may be performed outside of the United States, but will be paid as out-of-network benefits.

HABILITATIVE

Habilitative services for maintenance/preventive treatment.

MARIJUANA

Refer to – “Alternative Treatments - Controlled Substance”

Recreational and medical uses of marijuana are not Covered Health Services. This Exclusion applies even if permissible by state law and it is used to treat a diagnosed medical condition.

MEDICAL SUPPLIES AND APPLIANCES

- Devices used specifically as safety items or to affect performance in sports-related activities – including a nasal cannula, connector, and mask.
- Medical Supplies (prescribed or not prescribed by a Physician). Excluded supplies include:
  - Ace Bandages

- Powered and non-powered exoskeleton devices. Deodorants, Filters, Lubricants, Appliance Cleaners, Adhesive,
  Adhesive Remover, and
  Tape ○ Diapers and Pads ○
  Elastic Stockings ○
  Gauze and Dressings ○
  Gloves and Alcohol
  Wipes ○ Thermometers
  ○ This exclusion does not
  apply to:
- Diabetic supplies for which benefits are provided as described under Prescription Drugs under Covered Health Services section. ○ Ostomy supplies for which benefits are provided as described under Ostomy Supplies under Covered Health Services section. ○ Urinary catheters for which benefits are provided as described under Urinary Catheters under Covered Health Services section.

MENTAL HEALTH, NEUROBIOLOGICAL DISORDERS – AUTISM SPECTRUM DISORDER SERVICES AND SUBSTANCE-RELATED AND ADDICTIVE DISORDERS SERVICES

In addition to all other exclusions listed in this section, Plan Exclusions – What is Not Covered, the exclusions listed directly below apply to services described under Mental Health, Neurobiological Disorders, and Substance-Related and Addictive Disorders Services and Autism Spectrum Disorder:

- Services performed in connection with conditions not classified in the current edition of the International Classification of
- Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association
- Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, gambling disorder, and paraphilic disorders
- Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes
- Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act
- Outside of initial assessment, unspecified disorders for which the Provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Transitional Living services
- Non-Medical 24-hour Withdrawal Management
- High intensity residential care, including American Society of Addiction Medicine (ASAM) criteria, for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

NUTRITION

- Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

- Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to specialized enteral formula for which benefits are provided as described under Enteral Nutrition under Covered Health Services section.
- Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.
- Individual and group nutritional counseling. This exclusion does not apply to medical or behavioral/mental health-related education and nutritional counseling services that are billed as Preventive Care or to nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true: (a) nutritional education is required for a disease in which patient self-management is an important component of treatment; and (b) there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

ORTHOTIC

- Orthotic appliances and devices that straighten or re-shape a body part, except as described under Durable Medical Equipment. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria.
- Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics and some types of braces, including orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease

PHYSICAL APPEARANCE

- Cosmetic Procedures - Examples:
  - Pharmacological regimens, nutritional procedures, or treatments
  - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures)
  - Skin abrasion procedures performed as a treatment for acne
- Sclerotherapy treatment of veins
- Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. Refer to Reconstructive Procedures.
- Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation
- Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
- Services received from a personal trainer
- Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under Reconstructive Procedures.

PRESCRIPTION DRUGS

The exclusions listed below apply to the Prescription Drugs portion of the Plan only.
When an exclusion applies to only certain Prescription Drugs, You can access www.myuhc.com through the Internet or by calling the telephone number on Your ID card for information on which Prescription Drugs are excluded.

- Self-injectable medications (excluded unless filled through UnitedHealthcare's Specialty Pharmacy Program). Refer to "Specialty Medications."
- Non-injectable medications given in a Physician's office, except as required in an Emergency.
- Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by UnitedHealthcare's designee, but no later than December 31st of the following calendar year. This exclusion does not apply if You have a lifethreatening sickness or condition (one that is likely to cause death within

- one year of the request for treatment). If You have a life-threatening sickness or condition, under such circumstances, benefits may be available for the New Pharmaceutical Product to the extent provided for in Covered Health Services.
  Pharmaceutical Products not included on a Tier of the Prescription Drug List (PDL) at the time the Prescription Order or Refill is dispensed. When a Pharmaceutical Product is not on an available Tier of the Prescription Drug List (PDL), but that has been prescribed as Medically Necessary and appropriate alternative, You or Your representative may request an exception to gain access to the excluded Pharmaceutical Product. For information about this process, contact the number on the back of Your ID card.
- For any condition, injury, sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Any Prescription Drug for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Available over-the-counter medications that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless UnitedHealthcare has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that UnitedHealthcare has determined are therapeutically equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year, and the UnitedHealthcare may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
- Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which benefits are provided in this document. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- Coverage for Prescription Drugs for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drugs for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- Certain Prescription Drugs that have not been prescribed by a Specialist Physician.
- Prescribed, dispensed or intended for use during an Inpatient Stay.
- Prescription Drugs, including new Prescription Drugs or new dosage forms, that UnitedHealthcare determines do not meet the definition of a Covered Health Service.
- A Prescription Drug that contains (an) active ingredient(s) available in and therapeutically equivalent to another covered Prescription Drug. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
- A Prescription Drug that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent to another covered Prescription Drug. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
- Certain Prescription Drugs for which there are therapeutically equivalent alternatives available, unless otherwise required by law or approved by UnitedHealthcare. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
- Certain unit dose packaging or repackaging of Prescription Drugs.

- Used for conditions and/or at dosages determined to be Experimental, Investigational or Unproven, unless UnitedHealthcare has agreed to cover an Experimental, Investigational or Unproven treatment.
- Medications used for cosmetic purposes.
- Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed.
- General vitamins, except for the following which require a Prescription Order or Refill: ○ Prenatal vitamins. ○ Vitamins with fluoride. ○ Single entity vitamins.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of sickness or injury.
  A Prescription Drug that contains marijuana, including medical marijuana. This exclusion does not apply to any FDAapproved drug that contains a purified drug substance derived from marijuana (such as Epidiolex - Prior Authorization is required).
- Dental products, including but not limited to prescription fluoride topicals.
- A Prescription Drug with an approved biosimilar or a biosimilar and therapeutically equivalent to another covered Prescription Drug. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug approved based on showing that it is highly similar to a reference product (a biological Prescription Drug) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
- Diagnostic kits and products.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
- Certain Prescription Drugs that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists You with the administration of a Prescription Drug.
- A Pharmaceutical Product for which Benefits are provided in the medical portion of the Plan. This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

PROVIDERS

- Services performed by a Provider who is a family member by birth or marriage, including Spouse, brother, sister, parent, or Child. This includes any service the Provider may perform on himself or herself
- Services performed by a Provider with Your same legal residence
- Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other

Provider, services that are self-'directed to a free-standing or Hospital-based diagnostic facility, services ordered by a Physician or other Provider who is an Employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other Provider:

- Has not been actively involved in Your medical care prior to ordering the service, or
- Is not actively involved in Your medical care after the service is received

NOTE: This Exclusion does **NOT** apply to mammography testing.

REPRODUCTION

- The following treatment-related services:

- Cryopreservation and other forms of preservation of reproductive materials except as described under Fertility. This exclusion does not apply to short-term storage (less than one year) and retrieval of reproductive materials for which Benefits are provided.
- Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
- Donor services and non-medical costs of oocyte or sperm donation such as donor agency fees.
- Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes.
    - Embryo exception: a second oocyte retrieval may be approved if there are fewer than 3 quality embryos available for transfer.
    - Oocyte exception: a second oocyte retrieval may be approved for the purpose of fertility preservation if there are fewer than 9 mature oocytes available for freezing.
- Natural cycle insemination in the absence of sexual dysfunction or documented congenital or acquired cervical disease or mild to moderate male factor.
- Ovulation predictor kits.

- The following services related to Gestational Carrier or Surrogate: ○ Fees for the use of a Gestational Carrier or Surrogate. ○ Insemination costs of Surrogate or transfer embryo to Gestational Carrier.
    - ○ Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.
- The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs): ○ Donor eggs – The cost of donor eggs, including medical costs related to donor stimulation and egg retrieval. This exclusion may not apply to certain procedures related to Assisted Reproductive Technologies (ART) as described under Fertility including the cost for fertilization (in vitro fertilization or intracytoplasmic sperm injection), embryo culture, and embryo transfer.
    - ○ Purchased donor sperm (i.e., clinic or sperm bank) – The cost of procurement and storage of donor sperm. This refers to purchasing donor sperm that has already been obtained and is frozen or choosing a donor from a database.
- The reversal of voluntary sterilization.
- Fertility services not received from a UHC Fertility Center of Excellence.
- In vitro fertilization that is not an Assisted Reproductive Technology.
- Artificial reproductive treatments done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.
- Fertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).
- Fertility treatment following unsuccessful reversal of voluntary sterilization.
- Fertility treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).

SERVICES PROVIDED UNDER ANOTHER PLAN

- Health services for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation
- If coverage under workers' compensation or similar legislation is optional for You because You could elect it, or could have it elected for You, Benefits will not be paid for any injury, sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected
- Health services for treatment of military service-related disabilities, when You are legally entitled to other coverage and facilities are reasonably available to You
- Health services while on active military duty

TRANSPLANTS

- Health services connected with the removal of an organ or tissue from You for purposes of a transplant to another person (donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's medical coverage)
- Health services for transplants involving animal organs
- Any multiple organ transplant not listed as a Covered Health Service, unless determined by UnitedHealthcare to be a proven procedure for the involved diagnoses

TRAVEL

- With respect to the UnitedHealthcare EPO Plan and UnitedHealthcare Harvard Pilgrim Plans - travel or transportation expenses for health services provided in a foreign country, unless required as Emergency Services.
- Non-Network benefits provided in a foreign country are covered under the UnitedHealthcare PPO and HSA Medical Plans – Plan Non-Network benefits apply.

VISION

- Eye-glasses
- Contact lenses
- Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia, and astigmatism including, but not limited to, procedures such as radial keratotomy, laser, and other refractive eye surgery

Refer to "Vision Plans" to view coverage through Vision Service Plan (VSP)

ALL OTHER EXCLUSIONS

- Autopsies and other coroner services and transportation services for a corpse.
- Charges for:
  - Missed appointments. ○ Room or facility reservations. ○ Completion of claim forms.
  - Record processing.
- Charges prohibited by federal anti-kickback or self-referral statutes.
- Diagnostic tests that are:
  - Delivered in other than a Physician's office or health care facility.
  - Self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests.
- Expenses for health services and supplies:
  - That do not meet the definition of a Covered Health Service.
  - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
  - That are received after the date Your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.
  - For which You have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Plan.
  - That exceed Eligible Expenses or any specified limitation in this document.
- In the event a Non-Network Provider waives, does not pursue, or fails to collect the Copayment, Coinsurance, any Deductible or other amount owed for a particular health service, no benefits are provided for the health service for which the Copayments, Coinsurance and/or Deductible are waived.
- Intracellular micronutrient testing
- Foreign language and sign language interpretation services offered by or required to be provided by a Network or Non-Network Provider.
- Long term (more than 30 days) storage of blood, umbilical cord or other material.
- Health services and supplies that do not meet the definition of a Covered Health Service. Covered Health Services are those health services including services, supplies or Pharmaceutical Products, which UnitedHealthcare determines to be all of the following:
  - Provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
  - Medically Necessary. ○ Described as a Covered Health Service in this document.
  - Not otherwise excluded in this document under this section, Plan Exclusions – *What is Not Covered*.
- Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

- Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments when:
  - Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration.
  - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under Clinical Trials
  - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
  - Required to obtain or maintain a license of any type.
- Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

UnitedHealthcare Medical Plans - Claims Procedures

This section provides You with information about:

- How and when to file a claim
- Covered Heath Services received by a Network Provider ○ You do not have to file a claim. UnitedHealthcare pays these providers directly.
- Covered Health Services received by a Non-Network Provider ○ You are responsible for filing a claim

UnitedHealthcare will pay Network Providers directly for Covered Health Services. If a Network Provider bills You for any Covered
Health Service, contact UnitedHealthcare at the number on Your ID card. However, You are responsible for paying Copayments, Deductibles, or Coinsurance to a Network Provider at the time of service, or when You receive a bill from the Provider. When You receive a Covered Health Service from a Non-Network Provider, You are responsible for requesting payment from UnitedHealthcare.
You must file the claim in a format that contains all of the information in the section “Filing a Claim.”

FILING A CLAIM

You **MUST** submit a request for payment of benefits within one year after the date of the service**. If You do not provide this information to UnitedHealthcare within one year of the date of service, benefits for that health service will be denied or reduced, at UnitedHealthcare’s discretion.** If Your claim is for an Inpatient stay, the date of service is the date Your Inpatient stay ends. The time limit does not apply if You are legally incapacitated.

Required Information

When You request payment of benefits from UnitedHealthcare, You must provide all of the following information:

- The Employee’s name and address
- The patient’s name, age, and relationship to the Employee
- The member and group number stated on Your ID card
- An itemized bill from Your provider that includes the following:
  - Patient diagnosis ○ Date(s) of service ○ Procedure Code(s) and descriptions of service(s) rendered ○ Charge for each service

rendered, and ○ Provider of service name, address and Tax Identification Number The date the injury or sickness began.

- A statement indicating either that You are, or You are not, enrolled for coverage under any other health insurance plan or program. If You are enrolled for other coverage, You must include the name of the other carrier(s).

UnitedHealthcare will notify You if additional information is needed to process the claim. UnitedHealthcare will pend Your claim until information is received.

Payment of Benefits

Except as required by the No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260), You may not assign, transfer, or in any way convey Your Benefits under the Plan or any cause of action related to Your Benefits under the Plan to a Provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or UnitedHealthcare or its affiliates liable for payments to a Provider or to a third party to whom You may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to "third parties" include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from Providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for UnitedHealthcare (as determined in its sole discretion), UnitedHealthcare may make payment of Benefits directly to a Provider.

Any such payment to a Provider:

- is NOT an assignment of Your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to Your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or UnitedHealthcare from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for Your convenience is made, the Plan's obligation to You with respect to such Benefits is extinguished by such payment. If any payment of Your Benefits is made to a Provider as a convenience to You, UnitedHealthcare will treat You, rather than the Provider, as the beneficiary of Your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a Provider by any amounts that the Provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan), pursuant to Overpayments and Underpayment in Coordination of Benefits section.

Eligible Expenses due to a Non-Network Provider for Covered Health Services that are subject to the No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260) are paid directly to the Provider.

BENEFIT DETERMINATIONS

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. If Your post-service claim is denied, You will receive a written notice from UnitedHealthcare within 30 days of receipt of the claim, as long as all needed information was provided with the claim. UnitedHealthcare will notify You within this

30-day period if additional information is needed to process the claim, and may request a onetime extension not longer than 15 days and pend Your claim until all information is received.

Once notified of the extension You then have 45 days to provide this information. If all of the needed information is received within the 45-day period and the claim is denied, UnitedHealthcare will notify You of the denial within 30 days after the information is received. If You do not provide the needed information within the 45-day period, Your claim will be denied.

Pre-Service Claims

Pre-service claims are those claims that require notification or approval prior to receiving medical care. If Your claim was a preservice claim, and was submitted properly with all needed information, You will receive written notice of the claim decision from
UnitedHealthcare within 15 days of receipt of the claim. If You filed a pre-service claim improperly, UnitedHealthcare will notify You

of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, UnitedHealthcare will notify You of the information needed within 15 days after the claim was received, and may request a one-time extension not longer than 15 days and pend Your claim until all information is received.

Once notified of the extension You then have 45 days to provide this information. If all of the needed information is received within the 45-day period, UnitedHealthcare will notify You of the determination within 15 days after the information is received. If You do not provide the needed information within the 45 days period, Your claim will be denied.

Urgent Claims that Require Immediate Action

Urgent care claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize Your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of Your medical condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72 hours after UnitedHealthcare receives all necessary information, taking into account the seriousness of Your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If You filed an urgent care claim improperly, UnitedHealthcare will notify You of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, UnitedHealthcare will notify You of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after the earlier of:

- UnitedHealthcare's receipt of the requested information; or
- The end of the 48-hour period within which You were to provide the additional information, if the information is not received within that time.

Notice of Denial

In the event any post-service, pre-service or urgent care claim for benefits is denied, in whole or in part, UnitedHealthcare shall notify You of such denial in writing. Such written notice shall set forth, in a manner calculated to be understood by You, the following information:

(i) The specific reason(s) for the denial; and

(ii) Reference to the specific Plan provision(s) on which the denial is based; and

(iii) A description of any additional material or information necessary for You to perfect the claim and an explanation of why such material or information is necessary; and

(iv) A description of the plan's review procedures, including external review, and the time limits applicable to such procedures, including a statement of Your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination after completion of all levels of review required by the Plan; and

(v) If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim, either the specific rule,
guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol or other similar criterion was relied upon in denying the claim, and that a copy of such rule, guideline, protocol, or other similar criterion will be provided to the claimant free of charge upon request; and

(vi) If the denial is based on a Medically Necessary or experimental treatment or similar Exclusion or limit, either an explanation
of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, or a statement that such explanation will be provided to You free of charge upon request; and

In accordance with the Patient Protection and Affordable Care Act, in addition to the foregoing, the notice shall be written in a culturally and linguistically appropriate manner and will include the following information, as applicable:

(vii) Information sufficient to identify the claim involved, including the date of the service, the health care Provider, the claim amount (if applicable), a statement regarding the right to obtain the diagnosis code and treatment code and their corresponding meanings upon written request; and

(viii) For an adverse benefit determination or final internal adverse benefit determination, the denial code and its corresponding meaning, as well as a description of the plan's standard, if any, that was used in denying the claim.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and Your request to extend the treatment is an urgent care request for benefits as defined above, Your request will be decided within 24 hours, provided Your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on Your request for the extended treatment within 24 hours from receipt of Your request. If Your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care request for benefits and decided according to the timeframes described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and You request to extend treatment in a non-urgent circumstance, Your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions and Appeals

For questions on claims and benefit determinations, please contact customer service at the phone number on Your ID card. If customer service cannot resolve the issues to Your satisfaction, over the phone You may submit Your question in writing. Please see the Appealing a Denied Claim under the UnitedHealthcare Plans section, below for details on how to appeal a claim payment.

APPEALING A DENIED CLAIM

WHAT TO DO FIRST

If Your question or concern is about a benefit determination, or the rescission of Your coverage within the meaning of the Patient Protection and Affordable Care Act, You may informally contact the UnitedHealthcare Customer Service (at the number on Your ID card) before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to Your satisfaction over the phone, You may submit Your question in writing. However, if You are

not satisfied with a benefit determination as described in the UnitedHealthcare Claims Procedures section above, or the determination to rescind Your coverage, You may appeal it as described below, without first informally contacting Customer Service.

If You first informally contact Customer Service and later wish to request a formal appeal in writing, You should contact Customer Service and request an appeal. If You request a formal appeal, a Customer Service representative will provide You with the appropriate address of UnitedHealthcare.

If You are appealing an Urgent Care Claim denial, please refer to the Urgent Claim Appeals That Require Immediate Action section below and contact Customer Service immediately.

The Customer Service telephone number is shown on Your ID card. Customer Service representatives are available to take Your call during regular business hours (i.e., 8 a.m. to 8 p.m., for all time zones.), Monday through Friday.

HOW TO APPEAL A CLAIM DECISION

If You disagree with a claim determination after following the above steps or the determination to rescind Your coverage, You can contact UnitedHealthcare in writing to formally request an appeal. If the appeal relates to a claim for payment, Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The Provider's name.
- The reason You believe the claim should be paid.
- Any documentation or other written information to support Your request for claim payment.

Your first appeal request must be submitted to UnitedHealthcare within 180 days after You receive the claim denial. You should submit all information that You feel supports Your claim. **If You fail to appeal a denied claim within the 180-day period, UnitedHealthcare's claim determination will be final and binding.**

APPEAL PROCESS

If You request a review of a denied claim or the rescission of Your coverage, the following procedures shall apply:

- You shall have the opportunity to submit written comments, documents, records, and other information relating to the claim; and
- You shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to Your claim for benefits (other than legally or medically privileged documents); and
- The review shall take into account all comments, documents, records, and other information submitted by You relating to the claim, without regard to whether such comments, documents, records, and other information were submitted or considered in the initial benefit determination; and
- The review shall not afford deference to the initial claim denial and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of that individual;
- In deciding an appeal that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and such health care professional shall not be the individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal (nor the subordinate of such individual); and
- You shall be provided with, upon request, the identification of any medical or vocational experts whose advice was obtained on behalf of the plan in connection with Your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

- In accordance with the Patient Protection and Affordable Care Act, You may request a review of the entire claim file and may present evidence and written testimony in support of Your claim or appeal; provided, however, that You shall not be permitted to present evidence and written testimony in person. You will also be provided (free of charge) with new or additional evidence considered, relied upon, or generated by UnitedHealthcare in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage and a reasonable opportunity for You to respond to such new evidence or rationale.

For purposes of the Appeal Process, Relevant means a document, record, or other information that:

- Was relied upon in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- Demonstrates compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

APPEALS DETERMINATIONS

Pre-Service and Post-Service Claim Appeals

You will be provided written or electronic notification of decision on Your appeal as follows:

- For appeals of pre-service claims (as defined in Claims Procedures), the first level appeal will be conducted and You will be notified by UnitedHealthcare of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and You will be notified by UnitedHealthcare of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims (as defined in Claims Procedures), the first level appeal will be conducted and You will be notified by UnitedHealthcare of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and You will be notified by UnitedHealthcare of the decision within 30 days from receipt of a request for review of the first level appeal decision.
- If You are not satisfied with the first level appeal decision of UnitedHealthcare, You have the right to request a second level appeal from UnitedHealthcare. Your second level appeal request must be submitted to UnitedHealthcare within 60 days from receipt of first level appeal decision. **If You fail to appeal a denied claim within the 60-day period, UnitedHealthcare's claim determination will be final and binding.**
- For pre-service and post-service claim appeals, we have delegated to UnitedHealthcare (including United Behavioral

Health and Optum) the exclusive right to interpret and administer the provisions of the Plan. **UnitedHealthcare's (including United Behavioral Health's and Optum's) decisions are conclusive and binding.** Please note that UnitedHealthcare's (including United Behavioral Health's and Optum's) decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between You and Your Physician.

Urgent Claim Appeals

- Your appeal may require immediate action if a delay in treatment could significantly increase the risk to Your health or the ability to regain maximum function or cause severe pain.
- In these urgent situations, the appeal does not need to be submitted in writing. You or Your Physician should call

UnitedHealthcare as soon as possible. UnitedHealthcare will provide You with a written or electronic determination within 72 hours following receipt of Your request for review of the determination taking into account the seriousness of Your condition. If Your request for benefits is incomplete, UnitedHealthcare will notify You of the incomplete request for review and how to correct it within 24 hours after the urgent appeal was received. If additional information is needed to process the appeal, UnitedHealthcare will notify You of the information needed within 24 hours after the appeal is received. You then have 48 hours to provide the requested information. UnitedHealthcare will notify You of its benefit determination within 72 hours of receiving the requested information.

- For urgent claim appeals, we have delegated to UnitedHealthcare the exclusive right to interpret and administer the provisions of the Plan. UnitedHealthcare's decisions are conclusive and binding.

Notice of Denial on Appeal

In the event any post-service, pre-service or urgent care claim appeal is denied, in whole or in part, UnitedHealthcare shall notify You of such denial in writing. Such written notice shall set forth, in a manner calculated to be understood by You, the following information:

- The specific reason(s) for the denial; and
- Reference to the specific Plan provision(s) on which the denial is based; and
- A statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to Your claim for benefits; and
- A statement describing any voluntary appeal procedures offered by the plan, including external review, and Your right to obtain the information about such procedures, and a statement of Your right to bring an action under Section 502(a) of ERISA following the completion of all levels of appeal required by the Plan;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol or other similar criterion was relied upon in denying the claim, and that a copy of such rule, guideline, protocol, or other similar criterion will be provided to You free of change upon request; and
- If the denial is based on a Medically Necessary or experimental treatment or similar Exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, or a statement that such explanation will be provided to You free of charge upon request.

In accordance with the Patient Protection and Affordable Care Act, in addition to the foregoing, the notice shall be written in a culturally and linguistically appropriate manner and will include the following information, as applicable:

- Information sufficient to identify the claim involved, including the date of the service, the health care Provider, the claim amount (if applicable), a statement regarding the right to obtain the diagnosis code and treatment code and their corresponding meanings upon written request; and
- For an adverse benefit determination or final internal adverse benefit determination, the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a final internal adverse benefit determination, this description shall also include:
    - A discussion of the decision; and
    - A description of the external review process and how to initiate an appeal; and
    - A description of the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act section 2793.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and Your request to extend the treatment is an urgent care claim as defined above, Your request will be decided within 24 hours. UnitedHealthcare will make a determination on Your request for the extended treatment within 24 hours from receipt of Your request.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and You request to extend treatment in a non-urgent circumstance, Your request will be considered a new request and decided according to the postservice or pre-service timeframes, whichever applies.

EXTERNAL REVIEW PROGRAM

If, after exhausting Your internal appeals, You are not satisfied with the determination made by UnitedHealthcare, or if
UnitedHealthcare fails to respond to Your appeal in accordance with applicable regulations regarding timing, You may be entitled to request an external review of UnitedHealthcare determination. The process is available at no charge to You. If one of the above conditions is met, You may request an external review of adverse benefit determinations based upon any of the following:

- clinical reasons;
- the Exclusions for Experimental, Investigational or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or as otherwise required by applicable law.

You or Your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or Your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on Your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date You received UnitedHealthcare's decision. An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- Your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

1. Standard External Review
2. Expedited External Review

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by UnitedHealthcare of the request;
- a referral of the request by UnitedHealthcare to the IRO; and a decision by the IRO.
- Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:
- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to You. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests either by rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify You in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept, and consider additional information submitted by You after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making XYZ Company's determination. The documents include:

- all relevant medical records
- all other documents relied upon by UnitedHealthcare
- all other information or evidence that You or Your Physician submitted. If there is any information or evidence, You or Your Physician wish to submit that was not previously provided, You may include this information with Your external review request, and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by
UnitedHealthcare. The IRO will provide written notice of its determination (the “Final External Review Decision”) within 45 days after it receives the request for the external review (unless they request additional time and You agree). The IRO will deliver the notice of Final External Review Decision to You and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare’s determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the health care service or procedure.

Expedited External Review
An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances, You may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if You receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and You have filed a request for an expedited internal appeal; or
- a final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of
  care, continued stay, or health care service, procedure or product for which the individual received Emergency Services, but has not been discharged from a facility.
- Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:
  - is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
  - has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to You. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by
UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to You and to UnitedHealthcare.
You may contact UnitedHealthcare at the toll-free number on Your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Independent Review Organization (IRO)
For purposes of External Review, “Independent Review Organization” or “IRO” means the entities contracted by UnitedHealthcare to conduct independent external reviews with respect to certain denied claims and rescissions of coverage as required by the Patient Protection and Affordable Care Act and regulations issued there under as they may be amended from time to time.

YOUR FINAL RECOURSE – AFTER EXHAUSTION OF REMEDIES

If You disagree with the final decision on Your appeal, You have the right under Section 502(a) of ERISA to file suit in a state or federal court located in San Francisco, California. You must do so within one year after You have exhausted all steps in the UnitedHealthcare Claims Procedures and Appealing a Denied Claim under the UnitedHealthcare Plans sections above.

Coordination of Benefits – UnitedHealthcare Medical Plans

BENEFITS WHEN YOU HAVE COVERAGE UNDER MORE THAN ONE PLAN

This section describes how benefits under the ACME UnitedHealthcare Medical Plans will be coordinated with those of any other plan that provides benefits to You.

WHEN DOES COORDINATION OF BENEFITS APPLY?

This Coordination of Benefits (COB) provision applies to You if You are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The Secondary Plan may determine its benefits based on the benefits paid by the Primary Plan. How much this Plan

will reimburse You, if anything, will also depend in part on the Allowable Expense. The term, “Allowable Expense,” is further explained below.

WHAT ARE THE RULES FOR DETERMINING THE ORDER OF BENEFIT PAYMENTS?

Order of Benefit Determination Rules

The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

Primary Plan. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.

Secondary Plan. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

B. When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.

C. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent**. The Plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with

responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

a. The Plan covering the Custodial Parent.

b. The Plan covering the Custodial Parent's spouse.

c. The Plan covering the non-Custodial Parent.

d. The Plan covering the non-Custodial Parent's spouse.

For purpose of this section, Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph

3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.2(d)(i) can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.2(d)(i) can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

HOW ARE BENEFITS PAID WHEN THIS PLAN IS SECONDARY?

If this Plan is secondary, it determines the amount it will pay for a Covered Health Services by following the steps below:

- The Plan determines the amount it would have paid based on the Allowable Expense.
- If this Plan would have paid the same amount or less than the Primary Plan paid, this Plan pays no Benefits.
- If this Plan would have paid more than the Primary Plan paid, the Plan will pay the difference.

You will be responsible for any applicable Copayment, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the Allowable Expense.

HOW IS ALLOWABLE EXPENSE DETERMINED WHEN THIS PLAN IS SECONDARY

What is an Allowable Expense? For purposes of COB, an Allowable Expense is a health care expense that is covered at least in part by one of the health benefit plans covering You.

When the Provider is a Network Provider for both the Primary Plan and this Plan, the Allowable Expense is the Primary Plan's network rate. When the Provider is a Network Provider for the Primary Plan and a Non-Network Provider for this Plan, the Allowable Expense is the Primary Plan's network rate. When the Provider is a Non-Network Provider for the Primary Plan and a Network Provider for this

Plan, the Allowable Expense is the reasonable and customary charges allowed by the Primary Plan. When the Provider is a NonNetwork Provider for both the Primary Plan and this Plan, the Allowable Expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When this Plan is Secondary to Medicare".

WHAT IS DIFFERENT WHEN YOU QUALIFY FOR MEDICARE?

Determining Which Plan is Primary When You Qualify for Medicare

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (However, for employees enrolled in the HSA Plan, their Domestic Partners are excluded as provided by Medicare. For employee's enrolled in a UnitedHealthcare Plan (other than the HSA Plan), their Domestic Partners are not excluded (i.e., the Plan pays primary, Medicare pays secondary)).
- Cobra participants age 65 or older enrolled in a UnitedHealthcare Plan, excluding the HSA Plan.
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When this Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the Allowable Expense, as long as the Provider accepts reimbursement directly from Medicare. If the Provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such Providers a percentage of its approved charge – often 80%.

If the Provider does not accept assignment of Your Medicare benefits, the Medicare limiting charge (the most a Provider can charge You if they don't accept Medicare – typically 115% of the Medicare-approved amount) will be

the Allowable Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the Allowable Expense.

If You are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if You have enrolled in Medicare but choose to obtain services from an Opt-out Provider or one that does not participate in the Medicare program or a Provider who does not accept assignment of Medicare benefits, Benefits will be paid on a secondary basis under this Plan and will be determined as if You timely enrolled in Medicare and obtained services from a Medicare participating Provider.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience
UnitedHealthcare will use the Provider's billed charges for covered services as the Allowable Expense for both the Plan and Medicare.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If You do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, Your claim for Benefits will be denied.

DOES THIS PLAN HAVE THE RIGHT OF RECOVERY?

Overpayment and Underpayment of Benefits

If You are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays You more than it owes under this COB provision, You should pay the excess back promptly. The Plan Sponsor also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care Provider, UnitedHealthcare reserves the right to recover the excess amount from the Provider pursuant to Refund of Overpayments, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan’s obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by You, but all or some of the expenses were not paid by You or did not legally have to be paid by You.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, You agree to help the Plan get the refund when requested.

If the refund is due from You and You do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for You that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the

overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which UnitedHealthcare processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- equal the amount of the required refund, or
- if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.

The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

Definitions

ALTERNATE FACILITY

A health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services
- Emergency Health Services
- Rehabilitative, laboratory, diagnostic or therapeutic services

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

AIR AMBULANCE

Medical transport by rotary wing air ambulance or fixed wing air ambulance helicopter or airplane as defined in 42 CFR 414.605.

ANCILLARY SERVICES

Items and services provided by Non-Network Physicians at a Network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology.
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by a Non-Network Physician when no other Network Physician is available.

ANNUAL BENEFITS COMPENSATION

The Annual Benefits Compensation is used to determine Your Life/AD&D and Long Term Disability Insurance, and ACME's contribution (seed) to the HSA Medical Plan.

Your Annual Benefits Compensation effective January 1, 2024 includes Your base salary as of October 1, 2023 plus any ACME performance-based bonuses, ACME commissions, shift differentials and overtime paid to You from October 1, 2022 through September 30, 2023. Compensation paid outside of the specified period due to payment timing, errors, and/or omissions will NOT be counted in Your current Annual Benefits Compensation - it will be included in Your following year's Annual Benefits Compensation.

If You are an hourly paid Employee, base salary will be based upon Your hourly rate of compensation multiplied by the number of hours You are scheduled to work for that Calendar Year. If You worked for a non-US ACME entity prior to joining ACME America, Inc., those bonuses, commissions, shift differentials, and overtime will not be included in Your Annual Benefits Compensation. If You are a rehire, bonuses, commissions, shift differentials and overtime paid to You during October 1, 2022 through September 30, 2023 will be included.

If You are a new Employee of ACME through an acquisition, any compensation paid to You prior to legal entity combination (LEC) or under a bonus or commission plan of the acquired company will not be included in Your Annual Benefits Compensation.

If You are a new hire with a start date on or after October 1, 2023, Your Annual Benefits Compensation for the 2024 Plan Year will be based on Your annual base salary in effect on Your hire date.

BALANCE BILLING

Balance Billing occurs when a Network or Non-Network Provider bills You for the difference between the Provider's billed charge and the Eligible Expense. For example, if the Provider's billed amount is $100 and the Eligible Expense is $70, the Non-Network Provider may bill You for the remaining $30. A Network Provider may not Balance Bill You for Covered Health Services.

BRAND PRESCRIPTION

A Prescription Drug that is either:

- manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- identified as a Brand Prescription based on available data resources, that classify drugs as either Brand or Generic based on a number of factors

All products identified as "Brand" by the manufacturer, pharmacy, and Your Physician may not be classified as Brand by UnitedHealthcare.

CALENDAR YEAR

See "Plan Year" .

CELLULAR THERAPY

Administration of living whole cells into a patient for the treatment of disease.

CIVIL UNION

A legally recognized arrangement similar to marriage.

CLINICAL TRIAL

A scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COINSURANCE

Coinsurance is Your share of the costs of a Covered Health Service, calculated as a percent (for example, 20%) of the Eligible Expenses or the Recognized Amount when applicable for the service. You pay Coinsurance and any Deductibles You owe. For example, if the Plan's Eligible Expense for an office visit is $100 and You have met Your Deductible, Your Coinsurance payment of 20% would be $20. The Plan pays the rest of the Eligible Expense.

COMPOUND MEDICATION

Medications with one or more ingredients that are prepared “on-site” by a pharmacist. Bulk chemicals are chemical ingredients used to produce a drug. Chemical ingredients alone are not approved by the FDA.

CONGENITAL ANOMALY

A physical developmental defect that is present at birth and is identified within the first twelve months of birth.

COPAYMENT

A Copayment is a fixed amount (for example, $15) You pay for a Covered Health Service, usually when You receive the service. The amount can vary by the type of Covered Health Service. Your medical Plan ID card will identify the Copayment You must pay at each office visit and for each prescription.

You are responsible for paying the lesser of the following:

- The applicable Copayment
- The Eligible Expense or the Recognized Amount when applicable.

COVERED HEALTH SERVICE(S) OR COVERED CHARGES

Covered Health Services or Covered Charges are those health services, including services, supplies or Pharmaceutical Products, which UnitedHealthcare determines to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing, or treating a sickness, injury, mental illness, substancerelated and addictive disorders, condition, disease or its symptoms
- Medically Necessary
- Take place when coverage under the Plan is in effect
- Occur prior to the effective date of any of the individual termination conditions set forth in this Plan document and Summary Plan Description
- Provided to a Covered Person who meets all eligibility requirements specified in the Plan
- Described in "Covered Health Services" and not excluded from the Plan as documented in "Plan Exclusions - What is Not Covered"

Decisions about whether to cover new technologies, procedures, and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies.

COVERED PERSON

Either the Employee or an enrolled Dependent only while enrolled and eligible for benefits under the Plan. References to "You" and "Your" throughout this Plan document and Summary Plan Description (SPD) refers to a Covered Person.

CUSTODIAL CARE

Care that helps people with daily living activities that most people are able to do for themselves. Some examples include eating, bathing, and dressing.

DEDUCTIBLE

The Deductible is the amount of covered expenses You pay each Calendar Year before the Plan begins to pay benefits unless otherwise specified as waived in the Medical Plan Comparison Chart. For example, if Your Deductible is $1,000, Your Plan will not pay anything until You have met Your $1,000 Deductible for Covered Health Services subject to the Deductible. The Deductible may not apply to all services. The amount that is applied to the Deductible is calculated on the basis of the Eligible Expenses or the Recognized Amount when applicable.

An individual, as part of family coverage, may begin to receive benefits after satisfying the individual Deductible. However, not every individual in family coverage must satisfy the individual Deductible before the family Deductible is satisfied. For example, if the individual Deductible is $200 and the family Deductible is $600, if three members of a four-member family satisfy the $200 individual Deductible, the family Deductible of $600 is satisfied. The fourth family member will not need to satisfy a Deductible to begin receiving benefits.

The following expenses do not apply to the Deductible:

- Penalties resulting from failure to fulfill Prior Authorization requirements for certain services, including but not limited to
  Cosmetic or Reconstructive Surgery, MRI, Private Duty Nursing, and Surgery
- Paycheck Contributions
- Non-Covered Charges
- Amounts in excess of the Eligible Expense (including amounts above R&C charges)

Coupons: The Plan may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Deductible.

DEFINITIVE DRUG TESTING

Test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or nonuse of a drug.

DENTAL NECESSITY

Dental Necessity is defined as a service or supply required for the diagnosis, care, or treatment of a dental condition. The service or supply must be widely accepted by professionals in the United States as effective, appropriate, and essential, based upon recognized standards of the health care specialty involved. Services are not considered Dental Necessity if they:

- are not accepted, necessary, or required for the diagnosed care or treatment of a dental condition
- do not require the technical skills of the provider
- are furnished for the comfort or convenience of the patient, caregiver, or the family, or
- are provided only because the person is Inpatient who could have been safely and adequately diagnosed or treated while not confined

DESIGNATED PROVIDER

A Provider and/or facility that:

- Has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- UnitedHealthcare has identified through UnitedHealthcare's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within Your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers. You can find out if your Provider is a Designated Provider by contacting UnitedHealthcare at www.myuhc.com or the telephone number on Your ID card.

DURABLE MEDICAL EQUIPMENT (DME)

Medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a sickness, injury or their symptoms.
- Is not disposable.

- Is generally not useful to a person in the absence of a sickness, injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

ELIGIBLE EXPENSE

Eligible Expenses (also referred to as Allowable Amount, Payment Allowance, and Negotiated Rate) for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the UnitedHealthcare or as required by law.

Eligible Expenses are determined in accordance with UnitedHealthcare's reimbursement policy guidelines or as required by law. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accepts.
- As determined by third party vendors and affiliates, such as Naviguard.

ACME has delegated to UnitedHealthcare and its affiliates (including, but not limited to United Behavioral Health and Optum) and its third party vendors the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Non-Network Benefits

- You are responsible for paying any difference between the Eligible Expenses and amount the Non-Network Provider bills You.
  If Your Non-Network Provider bills You more than the Eligible Expense, You may have to pay the difference. Refer to "Balance Billing."
- You are responsible for paying any amount billed that is greater than the Eligible Expense - Eligible Expenses are based on the following:
  - UnitedHealthcare's data resources (including the databases of third party vendors and affiliates , such as Naviguard) of competitive fees in the Non-Network Provider's geographic area (see Reasonable and Customary (R&C)) ○ The negotiated rates agreed to by UnitedHealthcare and the Non-Network Provider (if applicable)

EMERGENCY

An Emergency is considered a serious medical condition or symptom resulting from injury, sickness, or mental illness that is both of the following:

- Arises suddenly, and
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

EMERGENCY ROOM

A hospital room or area staffed and equipped for the reception and treatment of persons with conditions (as illness or trauma) requiring immediate medical care.

EMERGENCY HEALTH SERVICES

Emergency health services are the Covered Person's first treatment at a Hospital's Emergency Room immediately following the onset of an Emergency condition.

ESSENTIAL HEALTH BENEFITS

Essential Health Benefits include services and treatments in the following categories: Ambulatory Patient Services, Emergency Services,
Hospitalization, Maternity And Newborn Care, Mental Health and Substance Use Disorder Services, Including Behavioral Health Treatment, Prescription Drugs, Rehabilitative and Habilitative Services and Devices, Laboratory Services, Preventive and Wellness Services, Chronic Disease Management, and Pediatric Services.

EXCLUSIONS (EXCLUDED SERVICES)

Exclusions (Excluded Services) are health care services not covered by the Plan.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES

Medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications, or devices that, at the time UnitedHealthcare makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not as appropriate for the proposed use in any of the following:
  - AHFS Drug Information (AHFS DI) under therapeutic uses section; ○ Elsevier Gold Standard's Clinical Pharmacology under the indications section; ○ DRUGDEX System by Micromedex under the therapeutic uses section and has a strength recommendation rating of
    class I, class IIa, or class IIb; or ○ National Comprehensive Cancer Network (NCCN) drugs and biologics compendium category of evidence 1, 2A, or 2B.
- Subject to review and approval by any institutional review board for the proposed use (devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational).
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.
- Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

- Clinical Trials for which Benefits are available as described under Clinical Trials.
- If You are not a participant in a qualifying Clinical Trial and have a sickness or condition that is likely to cause death within one year of the request for treatment, UnitedHealthcare may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that sickness or condition. Prior to such consideration, UnitedHealthcare must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.

FORMULARY AND NON-FORMULARY PRESCRIPTION DRUGS

A Formulary is a list of Prescription Drugs covered by a health plan. When a Formulary is used, a health plan typically limits the specific Prescription Drugs that are covered or charges a different Out-of-Pocket expense (e.g., Copayment) based on its classification under the Formulary.

FULL –TIME EMPLOYEE

See "Eligible Employees"

GENERIC PRESCRIPTION

A Prescription Drug that is either:

- chemically equivalent to a Brand Prescription; or
- identified as a Generic Prescription based on available data resources, that classify drugs as either Brand or Generic based on a number of factors

All products identified as "Brand" by the manufacturer, pharmacy, and Your Physician may not be classified as Brand by UnitedHealthcare.

GENDER DYSPHORIA

A disorder characterized by the following diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association:

- *Diagnostic criteria for adults and adolescents:*
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
    - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    - A strong desire for the primary and/or secondary sex characteristics of the other gender. ○ A strong desire to be of the other gender (or some alternative gender different from one's assigned gender). ○ A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
    - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
  - The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.
- *Diagnostic criteria for children:*
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
    - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
    - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
    - A strong preference for cross-gender roles in make-believe play or fantasy play. ○ A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender. ○ A strong preference for playmates of the other gender.
    - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
    - A strong dislike of ones' sexual anatomy.
    - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

GENE THERAPY
Therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

GENETIC COUNSELING
Counseling by a qualified clinician that includes:

- Identifying Your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help You make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.
- Certified genetic counselors, medical geneticists and Physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

GENETIC TESTING
Exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

GESTATIONAL CARRIER
Gestational Carrier is a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

IATROGENIC INFERTILITY
An impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

IMMUNIZATION
When a person is protected against a disease through vaccination. This term is often used interchangeably with vaccination or inoculation.

INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT
A health care facility that:

 Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and Provides Emergency Health Services

INFERTILITY
A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery.

INPATIENT
A person who stays in a hospital for one or more nights for medical care or treatment.

INTENSIVE BEHAVIORAL THERAPY (IBT)

Outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors, and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include Applied Behavior Analysis (ABA), The Denver Model, and Relationship Development Intervention (RDI).

INTENSIVE OUTPATIENT TREATMENT

A structured outpatient treatment program

- For Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health.

MAINTENANCE MEDICATION

Maintenance medications are prescribed for chronic, long term (6 months+) conditions, and are taken on a regular, recurring basis. Examples of conditions that may require maintenance medications are high blood pressure, high cholesterol, and diabetes.

MAXIMUM LIFETIME BENEFIT

The maximum amount a health plan will pay in benefits to an covered individual during that individual's lifetime. Lifetime maximums may not be placed on Essential Health Benefits.

MEDICALLY NECESSARY

Health care services that are all of the following as determined by UnitedHealthcare or its designee, within UnitedHealthcare's sole discretion. The services must be:

- In accordance with "Generally Accepted Standards of Medical Practice"
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for Your sickness, injury, mental illness, substance-related and addictive disorders, disease, or its symptoms
- Not mainly for Your convenience or that of Your doctor or other health care provider
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of Your sickness, injury, disease or symptoms

Generally Accepted Standards of Medical Practice

Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. UnitedHealthcare reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within UnitedHealthcare's sole discretion.

UnitedHealthcare develops and maintains clinical policies that describe the "Generally Accepted Standards of Medical Practice" scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations

regarding specific services. These clinical policies (as developed by UnitedHealthcare and revised from time to time), are available to Covered Persons on www.myuhc.com by calling the number on Your ID card, and to Physicians and other health care professionals on www.UHCprovider.com.

See Prior Authorization

MENTAL HEALTH SERVICES

Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the
International Classification of Diseases section on Mental and Behavioral Disorders or the Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a condition is listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

MENTAL ILLNESS

Those mental health or psychiatric diagnostic categories listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a condition is listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

NETWORK PHARMACY

A retail or mail order pharmacy that has:

- entered into an agreement with UnitedHealthcare to dispense Prescription Drugs to Covered Persons;
- agreed to accept specified reimbursement rates for Prescription Drugs; and
- been designated by UnitedHealthcare as a Network Pharmacy

NETWORK PROVIDER

Providers and suppliers (e.g., Physicians and Facilities) who have a contract with UnitedHealthcare to provide Covered Health Services at a discount. A Network Provider is responsible for submitting claims, obtaining Prior Authorization (when applicable), and Out-ofPocket costs are usually lower than a Non-Network Provider.

A complete list of ACME's third party provider directories are available on the ACME US Benefits Website.

Enrolling in the Plan does not guarantee You receive Covered Health Services by a Network Provider due to one or more of the following reasons:

- A Physician's practice may be closed because the available appointment capacity has been reached
- The care You need requires a different type of health care Provider
- In the case of scheduled hospital visits, Your Physician may not have admitting privileges at the hospital of Your choice

NEW PHARMACEUTICAL PRODUCT

A Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ends on the earlier of the following dates:

- The date it is reviewed
- December 31st of the following calendar year

- In the case of scheduled hospital visits, Your Physician may not have admitting privileges at the hospital of Your choice

NON-MEDICAL 24-HOUR WITHDRAWAL MANAGEMENT

An organized residential service, including those defined in American Society of Addiction Medicine (ASAM), providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

NON-NETWORK PROVIDER

Providers and suppliers (e.g., Physicians and Facilities) who do not have a contract with UnitedHealthcare to provide health care services at a discount. Non-Network Providers are not responsible for submitting claims or obtaining Prior Authorization – the Covered Person is responsible. The cost of Covered Health Services is usually higher when received by Non-Network Providers.

With the exception of Emergency Services, the UnitedHealthcare EPO Medical Plan and Kaiser Permanente HMO Medical Plans require a Covered Person to receive Covered Health Services by Network Providers.

OUT-OF-NETWORK REIMBURSEMENT RATE

The amount the Plan will pay to reimburse You for a Prescription Drug that is dispenses at a non-Network Pharmacy the Out-ofNetwork Reimbursement Rate for a particular Prescription Drug dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sale tax.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum (also referred to as the Out-of-Pocket Limit) is the most You pay during the Calendar Year before the Plan begins to pay 100% of the Eligible Expense. This limit never includes Your premium, balance-billed charges, or health services that are not covered (Exclusions). Your Copayments, Deductibles, Coinsurance, Non-Network payments, apply to Your Out-of-Pocket Maximum.

The following expenses do not apply to the Out-of-Pocket Maximum:

- Penalties resulting from failure to fulfill Prior Authorization requirements for certain services including but not limited to – Cosmetic or Reconstructive Surgery, MRI, Private Duty Nursing, and Surgery
- Paycheck Contributions
- Non-Covered Charges
- Amounts in excess of the Eligible Expense (including amounts above R&C charges)

Coupons: The Plan may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Maximum.

OUTPATIENT

Someone who receives health services or treatments, but does not stay overnight at a hospital; when the patient does not stay in the hospital.

PALLIATIVE CARE

Health care services that seek to prevent or relieve the physical and emotional distress produced by a life-threatening medical condition or its treatment.

PART-TIME EMPLOYEE
Refer to "Eligible Employees"

PHARMACEUTICAL PRODUCT(S)
U.S. Food and Drug Administration (FDA)-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

PHYSICIAN
A Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional, or health care facility licensed, certified or accredited as required by state law. A Physician is consulted on an Inpatient or Outpatient basis. A Physician may also be, to the extent required by law, a practitioner who performs a service for which coverage is provided when it is performed by a Physician. See Provider.

PLAN
ACME America, Inc. Flexible Benefit Plan.

PLAN SPONSOR
The Plan Sponsor is ACME America, Inc.

PLAN YEAR
The Plan is administered on a Calendar Year basis, beginning on January 1 and ending on December 31.

PREFERRED DRUG LIST (PDL)
A list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to periodic review and modification.

PRESCRIPTION DRUGS
A medication or product that has been approved by the U.S. Food and Drug Administration (FDA) and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

For purposes of this Plan, Prescription Drugs include:

- Inhalers (with spacers)
- Insulin
- The following diabetic supplies:
- Standard Insulin Syringes With Needles
- Blood Testing Strips - Glucose
- Urine Testing Strips - Glucose
- Ketone Testing Strips and Tablets
- Lancets and Lancet Devices
- Insulin Pump Supplies, Including Infusion Sets, Reservoirs, Glass Cartridges, and Insertion Sets
- Glucose Meters
- Certain injectable medications administered in a Network Pharmacy

PRESUMPTIVE DRUG TEST

Test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

PREVENTIVE CARE

Health care services that help prevent disease. Flu shots and annual well-adult exam are examples of Preventive Care.

PRIOR AUTHORIZATION

Also referred to as Pre-Authorization, Prior Approval, or Precertification. Prior Authorization is a decision made by the Plan that a health care service, treatment plan, Prescription Drug, or Durable Medical Equipment (DME) is Medically Necessary. The Plan may require Prior Authorization for certain services before You receive them, except in an Emergency. Prior Authorization is not a promise the Plan will cover the cost. Additionally, refer to "UnitedHealthcare Plans Prior Authorization."

PROVIDER

Any health care professional (i.e., doctor, therapist, nurse, dentist, optometrist), or health care facility licensed, certified or
accredited as required by state law (i.e., laboratory, hospital or clinic) that provides medical care. See Physician.

PRIVATE DUTY NURSING

Nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- Services exceed the scope of intermittent care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

REASONABLE AND CUSTOMARY (R&C)

The amount paid for a Covered Health Service in a geographic area based on what Providers in the area usually charge for the same or similar medical service. R&C is used to determine the Eligible Expense for the majority of Covered Health Services performed by NonNetwork Providers.

RECOGNIZED AMOUNT

The amount which Copayment, Coinsurance and applicable Deductible, is based on for the below Covered Health Services when provided by Non-Network Providers.

- Non-Network Emergency Health Services.
- Non-Emergency Covered Health Services received at certain Network facilities by Non-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B2(d) of the Public Service Act. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

The amount is based on either:

1) An All Payer Model Agreement if adopted,
2) State law, or
3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Provider or facility.

The Recognized Amount for Air Ambulance services provided by a non-Network Provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense.

REMOTE PHYSIOLOGIC MONITORING

The automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a treatment plan related to a chronic and/or acute health illness or condition. The treatment plan will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

RESIDENTIAL TREATMENT FACILITY

Treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment approved by the Mental Health/Substance-Related and Addictive Disorders Services Administrator under the active participation and direction of a Physician and approved by the Mental Health/SubstanceRelated and Addictive Disorders Services Administrator.
- Offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services; ○ Room and board. ○ Evaluation and diagnosis. ○ Counseling.
  - ○ Referral and orientation to specialized community resources.
- A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

SECRETARY

As that term is applied in the No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260).

SKILLED NURSING

A term that refers to a patient's need of care or treatment that can only be done by licensed nurses.

SPECIALIST

A physician specialist focuses on a specific area of medicine to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

SPECIALTY MEDICATION

Specialty Medications are high-cost prescription medications used to treat complex or chronic conditions such as cancer, rheumatoid arthritis, and multiple sclerosis. Specialty Medications are generally not readily available at retail

pharmacies and often require special handling (like refrigeration during shipping) and administration (such as injection or infusion). Refer to “Specialty Medications.”

SUBSTANCE-RELATED AND ADDICTIVE DISORDERS SERVICES

Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a disorder is listed in the edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

SURROGATE

A female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg, the surrogate is biologically (genetically) related to the child.

TELEHEALTH (TELEMEDICINE)

Telehealth (also referred to as Telemedicine) is the use of medical information exchanged from one site to another via electronic communications to deliver Covered Health Services and improve a Covered Person’s clinical health status. Telehealth includes a variety of applications and services using two-way video, email, smart phones, wireless tools, and other forms of telecommunications technology.

Telehealth is healthcare offered that provides access to Physicians and other health professionals, which includes a range of services for acute non-emergency needs. Telehealth services may be with a Covered Person’s own Provider, which is billed as an office visit, or telehealth visits may be with ACME’s telehealth vendor, Amwell (see comparison chart for cost share).

Benefits are also provided for Remote Physiologic Monitoring.

THERAPEUTIC DONOR INSEMINATION (TDI)

Insemination with a donor sperm sample for the purpose of conceiving a child.

TOTAL DISABILITY

Generally speaking, Total Disability occurs when due to sickness or injury, You are unable to perform with reasonable continuity the essential duties necessary to pursue Your occupation in the usual or customary way.

TRANSITIONAL LIVING

Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in American Society of Addiction Medicine (ASAM) criteria, that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide stable and safe housing and the opportunity to learn how to manage activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UNPROVEN SERVICES

Health services, including medications and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials (two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received).
- Well-conducted cohort studies from more than one institution (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.).
- UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note: If You have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Care Service for that sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that sickness or condition.

URGENT CARE

Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away. Urgent Care is of a lesser severity level than a true Emergency and treatment by an Emergency Room is not required or appropriate. Urgent Care is not considered an Emergency – and reduced benefits will apply if Urgent Care treatment is received in an Emergency Room.

UNITEDHEALTHCARE MEDICAL GUIDELINES

Includes the Medical Policies, Medical Benefit Drug Policies, Clinical Guidelines, Coverage Determination Guidelines, Quality of Care Guidelines, Utilization Review Guidelines and corresponding update bulletins for UnitedHealthcare commercial plans as set forth at https://www.uhcprovider.com/en/policies-protocols/commercial-policies/commercial-medical-drug-policies.html.

YOU / YOUR

If eligible for coverage, the words "You" and "Your" refer to Covered Persons.

Dental Plans

This section of the Plan document and Summary Plan Description outlines the key features and provisions of the Dental Plan. For additional information, please review the Dental Plan Comparison Chart, which is incorporated herein by reference and is a part of this Plan document and Summary Plan Description.

DENTAL - PLAN CHOICES

❖ Dental Plan I

- Covers Preventive, Basic, and Major Services

- Does NOT cover Orthodontia Services ❖ Dental Plan II
- Covers Preventive, Basic, Major, and Orthodontia Services

DENTAL - NETWORK AND NON-NETWORK PROVIDERS

You are able to receive Covered Health Services from Network and Non-Network Providers. MetLife has agreed upon discounted costs for dental services performed by Network Providers. This means the cost of care from a Network Provider will usually be less than the cost of a Non-Network Provider. Network Providers are responsible for filing claims for services provided. When You use Non-Network Providers, You are ultimately responsible for the cost of services. In some cases, the Non-Network dentist will file claims for services provided. However, they are not required to file claims and may request You remit full payment at the time of service.

Metlife Network Provider (PDP Provider)

A MetLife Network Provider is a licensed dentist who has been selected by MetLife for inclusion in their Preferred Dental Program[11]. This select group of dentists is referred to as MetLife PDP Plus. Use MetLife's online web-based directory to locate MetLife PDP Plus Providers in Your area.

Find a MetLife PDP Provider

- Visit the MetLife website at www.metlife.com/Dental/Find/find.html
- This URL will take You directly to the MetLife Dentist Directory
- From the main page – select the Network type "PDP Plus"
- Then, based on Your preferences, You may complete the remaining search fields

The MetLife Dental Plans allow You to use any licensed Provider; however if You use a Network Provider, Your Out-of-Pocket expenses will be reduced because the Network Provider has agreed to render services at a reduced rate.

DENTAL - HOW THE PLAN WORKS

ID Cards

Dental ID cards are not issued (nor are they required by MetLife). You should notify Your dentist that You are a MetLife Dental participant and provide the MetLife group number (#300569). The dental office will verify Your eligibility with MetLife. You can print an ID card from the MetLife website (www.mybenefits.metlife.com) or access an ID card from the MetLife mobile app.

Deductible

An individual, as part of family coverage, may begin to receive benefits after satisfying the individual Deductible. However, not every individual in family coverage must satisfy the individual Deductible before the family Deductible is satisfied. For example, if the individual Deductible is $50 and the family Deductible is $150, if three members of a four-member family satisfy the $150 Deductible (three members x $50 Deductible = $150), the family Deductible of $150 is satisfied. The fourth family member will not need to satisfy a Deductible to begin receiving benefits.

The following expenses do not count towards satisfying the Deductible:

- Copayments
- Non-Covered Charges
- Amounts In Excess Of Reasonable and Customary Charges

[11] Preferred Dentist Program (PDP)- A program that offers covered individuals the opportunity to receive dental care from Dentists who are designated by MetLife as Preferred Providers. When dental care is given by Preferred Providers, the covered individual may incur less out of pocket cost for the services.

The MetLife Dental Plans do not cover any unnecessary services or supplies that do not meet Dental Necessity requirements. In addition, the Plan does not cover the cost of any service or supply that exceeds that of another service or supply sufficient to safely and adequately diagnose or treat the person's dental condition.

DENTAL – REASONABLE AND CUSTOMARY (R&C)

A Reasonable and Customary(R&C) rate is within the range of the most commonly recognized charges for each service in a geographic area. The MetLife determines the usual, customary, and reasonable rates for all services offered. The Plan does not cover expenses above R&C rates. R&C applies when using Non-Network Providers. The amount not in excess of the R&C rate is covered. The R&C rate for a service or supply is the lower of:

- the Provider's usual charge for furnishing it, and
- the charge MetLife determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In determining the R&C rate 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, MetLife may take into account factors such as:

- the complexity,
- 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.

DENTAL - PRE-DETERMINATION BENEFITS

If a dental bill is expected to be $300 or more, before the dentist starts the treatment, the individual can find out what dental expense benefits will be paid under this Plan. To do this, the individual should send a claim form to MetLife in which the dentist provides information to MetLife regarding: the work to be done; and what the cost will be.

MetLife will then inform the covered individual whether the work is a Covered Health Expense and what dental expense benefits are available under this Plan, if any. Expenses are not guaranteed to be covered and will be subject to all other provisions, limitations, and Exclusion under the Plan. Predetermination requests do not take into account Your eligibility at the time the service is performed or provisions relating to non-duplication of benefits or annual maximums. A pre-determination is not a guarantee of payment. This method should not be used for:

- Emergency Treatment; or
- Routine Oral Exams; or
- X-Rays, Cleaning, Scaling, and Fluoride Treatments; or Dental Services That Cost Less Than $300.

Requesting a pre-determination is not a requirement nor is it considered the submission of a claim. MetLife will respond to Your request based upon the information available at the time of the request. Because the actual claim that You later submit for reimbursement may contain additional or different information, the decision by MetLife on the predetermination request is not binding. Once You have received the service, submitted a claim, and all information regarding Your claim is received by MetLife, a final determination of Your claim will be made and communicated to You in accordance with the Dental Plan's claims procedure.

Full details on how to file a request for a pre-determination of benefits are shown on the claim form.

DENTAL - COVERED SERVICES

Preventive Services

Covered at 100% of PDP (Network) or R&C (Non-Network) **List of Covered Services:**

- Oral exams - twice per Calendar Year
- Prophylaxis/Cleaning – twice per Calendar Year
- Sealants – Once every 36 months for Children to age 19
- Topical application of sodium or stannous fluoride - Twice per Calendar Year for Children to age 19 X-rays for diagnosis
- Other X-rays not to exceed one full-mouth series in a 36-month period and one set of bitewings twice per Calendar Year **Note**: X-rays must be performed by the dentist or licensed dental hygienist under the dentist's supervision in order to be covered under the Plan. This is stipulated under "Dental Plan Exclusions - What is Not Covered."

Basic Services

Covered at 80% of PDP (Network) or R&C (Non-Network) after Deductible up to $2,500 per Calendar Year (combined Basic and Major Services)

List of Covered Services:

- Emergency palliative treatment
- Endodontic treatment - includes root canal therapy (once per tooth every 24 months)
- Extractions
- Fillings - covered expenses will include only those materials that are widely accepted and considered necessary for the specific tooth
- General anesthetics - given in connection with oral surgery or other covered dental services when Medically Necessary.
- Injection of antibiotic drugs
- Oral surgery - includes surgical extractions but does not include procedures covered under any medical plan Periodontal treatment and cleanings
- Periodontal surgery is covered every 36 months
- Scaling and root planing is covered once per 24 months
- Maintenance treatments not to exceed four per Calendar Year (including prophylaxis)
- Repair or recementing of crowns, inlays, bridgework or dentures
- Relining or rebasing of dentures but not more than once every 36 months
- Space maintainers for children to age 19
- TMJ appliances and splints
- Bruxism appliances

Major Services

Dental Plan I

 Covered at 50% of PDP or R&C after Deductible up to $2,500 per Calendar Year (combined Basic and Major Services

Dental Plan II

- Covered at 80% of PDP or R&C after Deductible up to $2,500 per Calendar Year (combined Basic and Major Services) **List of Covered Services:**
- Crowns, jackets, inlays, onlays, implants, and cast restorations – One every 5 years
- First installation of bridgework - To replace one or more natural teeth extracted while You or Your eligible Dependents are covered. Includes inlays and crowns as abutments.
- First installation of removable dentures - To replace one or more natural teeth extracted while You or Your covered Dependents are covered. Includes adjustments for the 6-month period after they were installed.
- Replacement of an existing removable denture or fixed bridgework by a new denture or the adding of teeth to a partially removable denture. Services must meet the "Replacement Rule"
- Replacement of an existing removable denture or fixed bridgework by new bridgework, or the adding of teeth to existing fixed bridgework. Services must meet the "Replacement Rule"

Orthodontic Services

- Applies to Dental Plan II Only
- Covered at 50% of PDP or R&C up to $2,500 Lifetime Maximum Benefit
- Orthodontic services and supplies including diagnostic procedures, surgery, and appliances

Important

» Replacement of lost, missing, or stolen orthodontic appliances will not be covered.

» Refer to the Dental Plan Comparison Chart for additional information about covered services

How Orthodontia is Paid

Applies to Dental Plan II Only

The Plan will pay 50% of covered orthodontia expenses, up to a Maximum Lifetime Benefit of $2,500. Payment of orthodontia benefits under the Plan will be made over the course of orthodontic treatment; with 20% of the orthodontia benefit paid on the date orthodontic bands are placed.

For example, Jane is scheduled to have orthodontic bands placed on January 1, 2024. Her orthodontic treatment is scheduled to last 24 months and the full cost for this treatment is $5,500. The total orthodontic benefit available to Jane is $2,500. As explained above, the Plan pays 50% of covered orthodontia expenses, up to a Maximum Lifetime Benefit of $2,500. Here, 50% of $5,500 (i.e., $2,70) is greater than the Maximum Lifetime Benefit of $2,500. Accordingly, the maximum orthodontic benefit Jane may claim is limited to $2,500.

On the date Jane's orthodontic bands are placed (i.e., January 1, 2024); the Plan will pay $500 (i.e., 20% of $2,500). Jane's remaining $2,000 in orthodontic claims will be divided over the course of her 24 months of orthodontic treatment and will be paid quarterly.

REPLACEMENT RULE

Certain replacements or additions to existing implants, dentures, or bridgework will be covered under the Dental I and Dental II Plans. However, Your dentist must supply MetLife with satisfactory proof that:

- The replacement or addition of teeth is required to replace teeth extracted after the present denture or bridgework was installed.
- The present denture or bridgework cannot be made serviceable and is at least five years old; or
- The present denture is an immediate, temporary one, which cannot be made permanent, and as a result, replacement by a permanent denture is needed and takes place within 12 months from the date the immediate temporary one was first installed.

DENTAL PLAN EXCLUSIONS - WHAT IS NOT COVERED

Payment of all benefits under the Plan is limited to treatment and services which are Dental Necessity (as defined above). If You select a more expensive course of treatment (for example, if You choose to have a crown where a filling could restore a tooth, or a specialized technique when a standard technique would suffice), MetLife will pay only the applicable percentage of the lesser fee. You will be responsible for the remainder of Your dentist's charges. In addition, only non-occupational accidental injuries and non-occupational diseases are covered. Occupational injuries are covered under Workers Compensation.

The following services and supplies are **not** covered under the Plan:

- Adjustment of a denture or bridgework within the first six months after it is installed by the same dentist who installed it.
- Any treatments, services, or supplies not prescribed, recommended, or approved by the patient's attending doctor or dentist.
- Any services or supplies rendered before the person's effective date of coverage.

- Any treatments, services or supplies not considered by MetLife to be a dental necessity for the diagnosis, care or treatment of illness or injury (even if prescribed, recommended or approved by the attending doctor or dentist).
- Charges that an individual is not legally obliged to pay
- Charges that are above the R&C rates
- Charges made only because there is health coverage
- Cosmetic services or supplies, including personalization, or characterization of dentures
- Experimental, Investigational or Unproven procedures, services, drugs, or supplies
- Replacement of a prosthetic device that is lost, missing or stolen
- Replacement of orthodontic devices that are lost, missing or stolen
- Services performed by anyone who is not a dentist or a licensed dental hygienist under a dentist's supervision
- Services and supplies which are for orthodontic treatment, unless otherwise specified as covered elsewhere in the Dental Plan Comparison Chart
- Services or supplies to increase vertical dimension, including dentures, crowns, inlay and onlays, bridgework or any other appliance or service
- Services and supplies which any school system is required to provide by law, which is covered by any workers' compensation or occupational disease laws or which is covered by any employer's liability laws
- Services and supplies provided or required because of service in the armed forces or because of governmental law
- Services or supplies which are covered in whole or in part under any other group Plan of an ACME entity
- Services or supplies to correct damage caused by an accident (this may be covered under Your medical plan)
- Services or supplies not listed as covered dental expenses
- Any services that are included in another charge will not be covered as a separate charge
- Service and supplies, which are for harmful habits
- Medication, except those specified elsewhere

EXTENSION OF DENTAL BENEFITS

Extension of Dental Benefits for Covered Employees and Dependents

If Your dental coverage ends, the MetLife Dental Plans will cover the services and supplies listed below if they were ordered while You were still covered and Your treatment is completed (or the device is installed) within 60 days after Your dental coverage ends. The services and supplies covered under this provision include:

- Dentures (full or partial) and fixed bridgework if the dentist took the impressions and prepared the abutment teeth while the patient was covered under the Plan.
- A crown, if the dentist took the impression and prepared the tooth for the crown while the patient was covered by the Plan.
- For fixed bridgework and crowns, the teeth must have been fully prepared if they will serve as retainers or support and they are being restored.

METLIFE DENTAL CLAIMS PROCEDURES

Filing a Dental Plan Claim

In most cases, when You use preferred Providers, they will handle the filing of claims on Your behalf, however they are not required to submit claims and may request payment at the time of service. The group number is #300569. If You use non-preferred Providers, You may be responsible for paying the Provider and handling the filing of claims directly with MetLife.

If You are required to file the claim Yourself, You must complete the MetLife Dental Claim Form located on the ACME US Benefits Website. Please be sure to include the following information on the claim form:

- The patient's name, date of birth and relationship to the Employee The Employee's name, address, date of birth and phone number An itemized bill from Your Provider that includes the following:
    - Dentist name, address and tax identification number (TIN) ○ Examination Notes ○ Date(s) of service ○ Procedure number(s) and descriptions of service(s) rendered ○ Fee for each service rendered
- If the patient is covered under more than one dental Plan, the name of the other carrier(s).

Please review the instructions on the Claim Form prior to submitting the claim to MetLife. Failure to provide complete information and signatures may cause delay or denial of benefits.

You or Your Provider should file the claim within 60 days of the date of service for the claim to be considered for payment. Failure to submit claims prior to this date may result in denial or reduction of benefits.

Urgent Care Claims Submission

A small number of claims for dental expense benefits may be urgent care claims. Urgent care claims for dental expense benefits are claims for reimbursement of dental expenses for services which a dentist familiar with the dental condition determines would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Of course, any such claim may always be submitted in accordance with the normal claim procedures. However, Your dentist may also submit such a claim to MetLife by telephoning MetLife and informing MetLife that the claim is an "Urgent Care Claim." Urgent Care Claims are processed according to the procedures set out above, however once a claim for urgent care is submitted, MetLife will notify You of the determination on the claim as soon as possible, but no later than 72 hours after the claim was filed. If You or Your covered Dependent does not provide MetLife with enough information to decide the claim, MetLife will notify You within 24 hours after it receives the claim of the further information that is needed. You will have 48 hours to provide the information. If the needed information is provided, MetLife will then notify You of the claim decision within 48 hours after MetLife received the information. If the needed information is not provided, MetLife will notify You or Your covered Dependent of its decision within 120 hours after the claim was received.

If Your urgent care claim is denied but You receive the care, You may appeal the denial using the normal claim procedures. If Your urgent care claim is denied and You do not receive the care, You can request an expedited appeal of Your claim denial by phone or in writing. MetLife will provide You any necessary information to assist You in Your appeal. MetLife will then notify You of its decision within 72 hours of Your request in writing. However, MetLife may notify You by phone within the periods above and then mail You a written notice.

METLIFE DENTAL – DENIED CLAIM APPEALS

Initial Determination

After You or Your authorized representative submits a claim for dental expense benefits to MetLife, MetLife will review Your claim and notify You of its decision to approve or deny Your claim.

Such notification will be provided to You within a 30-day period from the date You submitted Your claim; except for situations requiring an extension of time of up to 15 days because of matters beyond the control of the MetLife. If MetLife needs such an extension, MetLife will notify You prior to the expiration of the initial 30-day period, state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because You did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice

requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify You as to its claim decision. You will have 45 days to provide the requested information from the date You receive the notice requesting further information from MetLife. When the claim has been processed, You will be notified of the benefits paid. If any benefits have been denied, You will receive a written explanation.

If MetLife denies Your claim in whole or in part, the notification of the claims decision will state the reason why Your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge. If the claim is denied on the basis of a dental necessity or experimental treatment or a similar Exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or include a statement that such explanation will be provided free of charge upon request.

How To Appeal A Metlife Dental Claim

If MetLife denies Your claim, You or Your authorized representative may appeal the initial determination. The Plan provides for a twolevel appeal process. MetLife is the named fiduciary with respect to appeals and has sole discretion to interpret the terms of the dental Plan as well as any other information relating to claims and appeals. You must submit Your appeal to MetLife at the address indicated on the Claim Form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Plan Name (ACME America, Inc.)
- Employee's Name
- Employee's Address
- Patient's
  - Name ○ Age
  - Relationship to the Employee
- Reference To The Initial Decision
- Is Appeal Status 1) First or 2) Second Appeal of Initial Determination
- Explanation of why You are appealing the initial determination

Additional Information

As part of each appeal, You may submit any written comments, documents, records, or other information relating to Your claim. In addition, upon Your written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim.

MetLife will conduct a full and fair review of Your appeal. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that You submit relating to Your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review Your appeal will not be the same person as the person who made the initial decision to deny Your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny Your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination. Upon Your written request, MetLife will provide the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan, in connection with the denial, without regard to whether the advice was relied

upon in making the benefit determination. MetLife will notify You in writing of its decision within 30 days after MetLife's receipt of Your written request for review.

If MetLife denies the claim on appeal, MetLife will send You a written decision that states the reason(s) why the claim You appealed is being denied, references any specific Plan provision(s) on which the denial is based, and describes the procedure for filing a second appeal and the time limits associated with bringing a second appeal and Your right to bring an action under section 502(a) of ERISA following an adverse decision after a second appeal. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge. If the claim is denied on the basis of a dental necessity or experimental treatment or a similar Exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or include a statement that such explanation will be provided free of charge upon request. Upon written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim.

If You disagree with MetLife's decision on Your initial appeal, You or Your authorized representative may file a second appeal with MetLife. You must submit Your appeal to MetLife at the address indicated on the Claim Form within 180 days of receiving MetLife's decision on Your first appeal. You may submit written comments, documents, records, and other information relating to Your claim that You did not submit with Your previous appeal. You may also request to receive, free of charge, reasonable access to, or copies of, all documents, records, and other information relevant to Your claim for benefits.

MetLife will notify You in writing of its final decision within 30 days after MetLife's receipt of Your written request for a second appeal. If Your claim is denied, the notice will state the reason(s) why Your appeal is being denied, the Plan provision(s) on which the denial is based, and Your right to bring suit under section 502(a) of ERISA. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge. If the claim is denied on the basis of a dental necessity or experimental treatment or a similar Exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the medical circumstances, or include a statement that such explanation will be provided free of charge upon request. Upon written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim.

DENTAL - COORDINATION OF BENEFITS

If You or a Dependent is covered under one of the MetLife Dental Plans as well as another group dental plan, Your benefits from the other plan will be taken into account when calculating the benefit payments from this Plan. For example, if Your Spouse is covered under his or her employer's plan and ACME's Plan, MetLife will coordinate Your Spouse's benefits with the benefits received from the other plan.

When You or Your Dependents are covered under more than one group plan, allowable expenses are first charged to the primary plan (described below), up to that plan's limits. Any remaining covered expenses may then be paid by the secondary plan.

If this Plan is considered the primary plan, then this Plan will pay benefits first. You can then submit any amounts not paid by this Plan to Your other plan for possible additional payments.

If this Plan is considered the secondary plan, You should first send Your bill(s) to Your other plan (as primary) for payment. You can then submit a claim for any unreimbursed expenses (along with the explanation of benefits showing what the primary plan paid) to this Plan.

The Plan will then pay benefits up to either the total amount of Your allowable expenses, based on MetLife's Reasonable and Customary (R&C) rates, or the Plan's limits, whichever is less.

Dental – Determining Which Plan is Primary

MetLife will use the following rules to determine which plan is primary and which is secondary:

- No Coordination of Benefits - If the other plan does not have a coordination of benefits provision, that plan is primary and pays first.
- Non-Dependent - A plan, which covers a person other than as a Dependent, will be deemed to pay its benefits before a plan, which covers the person as a Dependent.
- Dependent Child If Parents Not Separated or Divorced - If a person is covered as a Dependent by both plans, the plan of the parent whose birthday is earlier in the year (not necessarily older) is primary and pays first. For example, if Your birthday is March 15 and Your Spouse's birthday is January 3, Your Spouse's plan would be primary and pay benefits for any covered Children first. If the other plan does not have a birthday provision, the rule set forth in that plan will determine the order of benefit payments. If both parents have the same date of birth, the plan covering the Dependent Child longest is the primary plan.
- Dependent Child Whose Parents Are Divorced or Separated - For Children of divorced or separated parents, the following rules apply:
    - If there is a court order which establishes financial responsibility, that parent's plan will pay first.
    - If there is no court order:
        - If the parent with majority custody of the Child has not remarried, that parent's plan is primary.
        - If the parent with majority custody has remarried, that parent's plan pays first, followed by the stepparent's plan (if any), and then by the plan of the parent without majority custody.
- Active/Inactive Employee or Dependent - The plan that covers a person as an Employee who is neither laid-off nor retired pays before the plan, which covers that person as a laid-off or retired Employee or Dependent.
- Continuation Coverage - The plan covering the person as an active or retired Employee (or Dependent of that Employee) pays before the plan which covers the individual as a COBRA beneficiary.
- Longer/Shorter Time Covered - If none of the above rules apply, the plan under which the person has been covered the longest will pay first, unless the person covered is:
    - Laid-off or retired, or ○ The Dependent of such a person.

In order to administer this coordination of benefits provision, MetLife has the right to release or obtain data. MetLife can also make or recover payments.

VISION PLANS

This section of the Plan Document and Summary Plan Description outlines the key features and provisions of the Vision Service Plan (VSP) Plans. For additional information about Plan coverage, refer to the Vision Plan Comparison Chart, which is incorporated herein by reference and is a part of this Plan document and Summary Plan Description.

VISION - PLAN CHOICES

The Plan offers You a choice of the following two vision Plans:

- **Vision Plan I** — Allows You to obtain glasses (frame & lenses) **or** contacts once every Calendar Year.
- **Vision Plan II** — Allows You to obtain glasses (frame & lenses) **or** contacts twice every Calendar Year. This Plan also provides a higher level of coverage for frames or elective contact lenses.

VISION – HOW THE PLAN WORKS

To access Your vision benefits, You can find a VSP doctor in Your area by visiting the VSP web site at www.vsp.com or calling VSP Member Services at 800-877-7195 and requesting a list of Network doctors. Call the VSP doctor of Your choice to schedule an appointment. VSP doctors will verify Your eligibility and will take care of any necessary forms.

ID Cards

Vision ID cards are not issued (nor are they required by VSP) and doctors will not request any form of Plan identification. VSP doctors will call VSP to verify eligibility.

How Benefits Eligibility is Determined

Your benefits eligibility for vision is based on a Calendar Year accumulation, even when You switch vision plans. Please contact VSP at 1-800-877-7195, or access the VSP website at www.vsp.com to obtain information on the date You last received an examination and/or purchased glasses (frames & lenses) and/or contacts and the date You will next be eligible to receive services.

Note: If You use a VSP doctor but do not have the doctor verify eligibility prior to receiving services, any benefits will be paid at the Non-Network benefit level.

VISION - CLAIM PROCEDURES

If You receive services from a non-VSP provider, You must follow these steps:

- Pay the provider the full amount of the bill and request a copy of the bill that shows the amount of the eye exam, lens type, and frame
- Visit the **Benefits** section of www.vsp.com to begin Your claim.
- Complete the claim form. Make sure You have a copy of Your itemized receipt or statement that includes: ○ Doctor name or office name ○ Name of Patient ○ Date of Service ○ Each service received and the amount paid
- After completing the claim form, You may attach Your receipt(s) or print and mail copies of Your claim form and receipt(s) to: Vision Service Plan (VSP)
  PO Box 495918
  Cincinnati, OH 45249-5918

VISION - PLAN EXCLUSIONS (WHAT IS NOT COVERED)

VSP pays in full any necessary spectacle lenses, including single vision, bifocal, trifocal or other more complex and expensive lenses necessary for Your visual welfare. You may elect lenses or lens characteristics that are not necessary for Your visual welfare, but You will pay for those cosmetic options. For example, You would be responsible for the costs for the following elective services and supplies:

- Blended or Progressive Multifocal Lenses (except standard progressive lenses)
- Cosmetic Lenses
- Frames In Excess of The Plan Allowance
- Optional Cosmetic Processes
- Oversize, Coated Or Laminated Lenses
- Certain Limitations On Low Vision Care
- Any Supplemental Tests or Fittings Associated With Contact Lenses
- Exam or Eye-Wear Required By An Employer As a Condition of Employment
- Medical or Surgical Treatment
- Non-Prescription Lenses (except following LASIK/PRK surgery)
- Vision Training
- Services During Periods of Ineligibility (e.g., services received outside the normal interval)

- Two Pairs of Lenses In Lieu Of Bifocals
- Contact Lenses Solution and Miscellaneous Supplies
- Low Level Prescription Lenses (i.e., any prescription under 0.5 diopters)

APPEALING A DENIED VSP CLAIM

Initial Determination

VSP will pay or deny claims within 30 calendar days of the receipt of the claim from the individual or their authorized representative. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than 15 calendar days. If VSP needs such an extension, VSP will notify You prior to the expiration of the initial 30-day period, state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because You did not provide sufficient information or filed an incomplete claim, the time from the date of VSP's notice requesting further information and an extension until VSP receives the requested information will not count toward the time period VSP is allowed to notify You as to its claim decision. You will have 45 days to provide the requested information from the date You receive the notice requesting further information from VSP. When the claim has been processed, You will be notified of the benefits paid. If any benefits have been denied, You will receive a written explanation.

If VSP denies Your claim in whole or in part, the notification of the claims decision will state the reason why Your claim was denied and reference the specific plan provision(s) on which the denial is based. If the claim is denied because VSP did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge. If the claim is denied on the basis of a medical necessity or experimental treatment or a similar Exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the medical circumstances, or include a statement that such explanation will be provided free of charge upon request.

Request for Appeals

If an eligible Employee's or Dependent's claim for benefits is denied by VSP in whole or in part, VSP will notify the individual in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, individual may make written request to VSP for a full review of such denial. The request should contain sufficient information to identify the individual for whom a claim for benefits was denied, including:

- The Employee's name and address
- The patient's name, age and relationship to the Employee
- The Employee's Member Identification Number
- The name of the Provider of services and claim number

The individual may state the reasons that he or she believes that the claim denial was in error. The individual may also provide any pertinent documents to be reviewed. VSP will review the claim and give the individual the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. The individual or individual's authorized representative should submit all requests for appeals to:

Vision Service Plan (VSP) Attn: Appeals Dept P.O. Box 2350 Rancho Cordova, CA 95741

VSP will conduct a full and fair review of Your appeal. Deference will not be given to initial denials, and VSP's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that You submit relating to Your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review Your appeal will not be the same person as the

person who made the initial decision to deny Your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny Your claim. If the initial denial is based in whole or in part on a medical judgment, VSP will consult with a health care professional with appropriate training and experience in the field of medicine involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination. Upon Your written request, VSP will provide the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan, in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

VSP will notify You in writing of its decision within 30 days after VSP's receipt of Your written request for review. If VSP denies the claim on appeal, VSP will send You a written decision that states the reason(s) why the claim You appealed is being denied, references any specific Plan provision(s) on which the denial is based, and describes the procedure for filing a second appeal and the time limits associated with bringing a second appeal and Your right to bring an action under section 502(a) of ERISA following an adverse decision after a second appeal. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge. If the claim is denied on the basis of a medical necessity or experimental treatment or a similar Exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or include a statement that such explanation will be provided free of charge upon request. Upon written request, VSP will provide You free of charge with copies of documents, records and other information relevant to Your claim.

If You disagree with VSP's decision on Your initial appeal, You or Your authorized representative may file a second appeal with VSP. You must submit Your appeal to VSP at the address indicated above within 60 days of receiving VSP's decision on Your first appeal.
You may submit written comments, documents, records, and other information relating to Your claim that You did not submit with Your previous appeal. You may also request to receive, free of charge, reasonable access to, or copies of, all documents, records, and other information relevant to Your claim for benefits.

VSP will notify You in writing of its final decision within 30 days after VSP's receipt of Your written request for a second appeal. If Your claim is denied, the notice will state the reason(s) why Your appeal is being denied, the Plan provision(s) on which the denial is based, and Your right to bring suit under section 502(a) of ERISA. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge. If the claim is denied on the basis of a medical necessity or experimental treatment or a similar Exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or include a statement that such explanation will be provided free of charge upon request. Upon written request, VSP will provide You free of charge with copies of documents, records and other information relevant to Your claim.

VISION - COORDINATION OF BENEFITS

If You or a family member is covered under one of the ACME Vision Service Plan (VSP) Plans as well as another group vision plan,
Your benefits from the other plan will be taken into account when calculating the benefit payments from this Plan. For example, if Your Spouse or Qualified Domestic Partner is covered under his or her employer's plan and ours, VSP will coordinate Your Spouse's benefits with the benefits received from the ACME Plan for Out-of-Pocket expenses, Deductibles, Copayments, non-covered options and frame coverage.

When You or Your Dependents are covered under more than one group plan, allowable expenses are first charged to the primary plan (described below), up to that plan's limits. Any remaining covered expenses may then be paid by

the secondary plan. If this Plan is considered the primary plan, then this Plan will pay benefits first. You can then submit any amounts not paid by this Plan to Your other plan for possible additional payments.

If this Plan is considered the secondary plan, You should first send Your bill(s) to Your other plan (as primary) for payment. You can then submit a claim for any unreimbursed expenses (along with the explanation of benefits showing what the primary plan paid) to this Plan. **VSP will then pay benefits up to either the total amount of Your allowable expenses or the Plan's limits, whichever is less.**

VISION - DETERMINING WHICH PLAN IS PRIMARY

When two or more plans provide vision benefits for the same person, benefits will be paid according to the following rules:

- The benefits of the plan that covers the person other than as a Dependent are determined before those of the plan that covers the person as a Dependent.
- When this Plan and another plan cover the same Child as a Dependent of parents who are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. This is called the "Birthday Rule." The year of birth is ignored. If both parents have the same birthday, the benefits of the plan that covered one parent longer are determined before those of the plan that covered the other parent for a shorter period.
- When this Plan and another plan cover the same Child as a Dependent of parents who are divorced or separated, the following rules apply:
    - If there is a court order which establishes financial responsibility, that parent's plan will pay first.
    - If there is no court order, the plan of the parent with majority custody of the Child is primary.

MEDICAL SECOND OPINION

Included Health offers second medical opinions from leading medical experts. It is a free service offered to ACME benefit-eligible employees and their dependents. Contact Included Health for assistance with an existing diagnosis or treatment. Included Health will:

- Give You a second opinion/personalized care plan from a leading expert
- Help You make decisions or help You decide if surgery is right for You
- Provide information about a new diagnosis or existing condition Contact Included Health at http://www.includedhealth/ACME or 1-888-868-4692.

HEALTH AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS (FSAs)

This section outlines the features and provisions of the General Purpose Health Care FSA, the Limited Purpose Health Care FSA, and the Dependent Care FSA.

The Internal Revenue Code (IRC) provides certain types of tax-advantaged financial arrangements such as Flexible Spending Accounts (FSAs). ACME offers two Health Care FSAs and a Dependent Care FSA – all are administered by UnitedHealthcare.

- General Purpose Health Care Flexible Spending Account (GPHC FSA)
- Limited Purpose Health Care Flexible Spending Account (LPHC FSA)
- Dependent Care Flexible Spending Account (DC FSA)

Health & Dependent Care FSA - Separate Accounts

Qualified health expenses for You and Your eligible dependents are covered under the Health Care FSA. The Dependent Care FSA covers qualified Childcare or elder care expenses. The accounts are separate - You cannot transfer money from one reimbursement account to the other.

Health Care FSA - General Purpose and Limited Purpose

You may enroll in either the General Purpose Health Care FSA or the Limited Purpose Health Care FSA; You may not enroll in both.

❖ **GENERAL PURPOSE HC FSA:**

- Applicable to qualified medical, pharmacy, dental, and vision expenses ❖

LIMITED PURPOSE HC FSA:

- Applicable to qualified dental and vision expenses only
- Cannot be used for qualified medical expenses
- Medical Plan Requirements ○ Enrolled in the ACME HSA Medical Plan; or
  ○ ACME Medical Plan coverage is "waived" and You are enrolled in a non-ACME IRS-qualified HDHP through an alternate source such as a Spouse or Qualified Domestic Partner

GENERAL AND LIMITED HEALTH CARE FSA

Tax Qualified Dependents

The Health Care Flexible Spending Account and the Limited Purpose Health Care Flexible Spending Account allow You to use pre-tax dollars to pay for eligible health care expenses (as outlined in Section 213(d) of the Code) incurred by You or Your "tax-qualified dependents." You may receive tax-favored reimbursements from the General Purpose Health Care FSA and the Eligible Expenses of the following "tax-qualified dependents"

- Your Section 152 Tax Dependent as defined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) of Section 152 of the Code (see definition below)
- Your Child who is under the age of 27 as of the end of the Plan Year

Section 152 Tax Dependent

To qualify as a Section 152 Tax Dependent (as defined without regard to subsections (b) (1), (b) (2), and (d) (1) (B) of Section 152 of the
Code), a person must be a U.S. citizen or national, or a resident of the U.S. or a country contiguous to the U.S., and must either be Your "IRS Qualifying Child" or "IRS Qualifying Relative."

IRS Qualifying Child

Generally, an individual is a taxpayer's "IRS Qualifying Child" if:

- The individual is the taxpayer's son, daughter, stepChild, foster Child, brother, sister, stepbrother, stepsister, or a descendant of any of them (for example, the taxpayer's grandchild, nephew or niece); and
- The individual lives with the taxpayer for more than half the year; and
- The individual is under age 19 for the entire Calendar Year or, if a full-time student, under age 24 for the entire Calendar Year or totally and permanently disabled; and
- The individual does not provide more than 50% of his or her own support for the year.

IRS Qualifying Relative

Generally, a person is a taxpayer's "IRS Qualifying Relative" if the person:

- Is not the taxpayer's or anyone else's "IRS Qualifying Child" (as defined above); and
- Receives over 50% of his or her support for the year from the taxpayer; and
- Is the taxpayer's relative (e.g., a parent, grandparent, Child, grandchild, sibling or in-law) or a non-relative (e.g., a Qualified Domestic Partner) if the non-relative, for the entire year, lives with the taxpayer and is a member of the taxpayer's household.

Tax Qualified Dependent

Generally, a Child is Your "tax-qualified Dependent" for purposes of the General and Limited Purpose Healthcare FSA if Your Child will be under age 27 at the end of the Calendar Year.

For this purpose, a "Child" is a son, daughter, stepson, stepdaughter or eligible foster Child as defined in Section 152(f) of the Internal Revenue Code or a Child who has been adopted by or placed for adoption with the taxpayer.

Please note, if Your Child is under the age of 27, he or she may be Your "tax-qualified Dependent" for General and Limited Purpose
Health Care FSA, even if he or she does not meet the definition of "IRS Qualifying Child" described above. For example, even if Your
Child does not depend on You for financial support or reside with You, You may still receive reimbursement for Your Child's eligible
General or Limited Purpose Health Care FSA expenses, as long as Your Child is under the age of 27 as of the end of the Calendar Year.

ANNUAL HEALTH CARE FSA ELECTION LIMIT

- You may contribute up to $3,050 each Calendar Year to the General Purpose Health Care Flexible Spending Account. The minimum contribution is $5 per paycheck or $120 per year.
- You may contribute up to $3,050 each Calendar Year to a Limited Purpose Health Care Flexible Spending Account. The minimum contribution is $5 per paycheck or $120 per year.

If Your Spouse is also eligible for a General and Limited Purpose Health Care FSA, You can each contribute the maximum amount to Your respective plan. In addition, if You participated in another employer's General or Limited Purpose Health Care FSA during the year, You may still contribute up to $3,050 to the General or Limited Purpose Health Care FSA. If You have a Qualified Family Status Change during the year and switch from a General to a Limited Purpose Health Care FSA (or vice versa), You may contribute up to a combined total of $3,050 to both accounts.

HEALTH CARE FSA - CARRYOVER PROVISION

You may carry over up to $610 of Your unused Health Care FSA money into the 2024 Plan Year (Note: the carryover amount from 2024 to 2025 is $640). This means that any unused balance (up to $610) can be used to pay for Eligible Expenses incurred in 2024. Such carryover amounts may be used for eligible medical expenses incurred during the entire year to which it is carried over. Thus, the maximum amount that You could be reimbursed in 2024 is $3,660. Any reimbursement of medical expenses incurred in a year will be treated as reimbursed first from Your contributions for such year and then as reimbursed from carried over amounts. If You participate in a General Purpose Health Care Flexible Spending Account for a year and elect to participate in the HSA Medical Plan for the following year, any carryover amount will be transferred to a Limited Purpose Health Care Flexible Spending Account.

HEALTH CARE FSA – ELIGIBLE EXPENSES

You generally may use the General Purpose Health Care Flexible Spending Account or the Limited Purpose Health Care Flexible
Spending Account to pay for health care expenses considered tax-deductible by the IRS. If You pay for expenses through a General Purpose Health Care Flexible Spending Account or a Limited Purpose Health Care Flexible Spending Account, You may not also take a tax deduction for those expenses. You are only eligible for the tax deduction if Your health care expenses exceed 7.5% of Your adjusted gross income.

NOTE: The Limited Purpose Health Care Flexible Spending Account only reimburses health care expenses that are dental or vision care in nature.

General Purpose Health Care FSA - Eligible Expenses

You may use the Health Care FSA to pay for eligible health care expenses as defined by the IRS.

The following is a **partial list of expenses eligible for reimbursement:**

- Acupuncture
- Alcoholism Treatment
- Ambulance
- Artificial limbs
- Braille books/magazines
- Car Controls for the disabled
- Chiropractors
- Coinsurance
- Crutches
- Deductibles
- Dental
- Dentures
- Drug/Medical Supplies
- Eyeglasses & Exams
- Hearing devices and batteries
- Hospital
- Insulin
- Laboratory
- Menstrual Care Products
- Nurse Obstetrics
- Orthodontics
- Orthopedic care
- OTC products and medications (without prescription)
- Physicians
- Psychiatric care
- Psychologist care
- Radial keratotomy surgery
- Non-diagnostic services
- Seeing-eye dog & maintenance
- Special education for the blind
- Surgical fees
- Phone equipment for the deaf
- Therapy for alcohol/drug addiction
- Therapy treatments
- Tuition for special schools
- Wheelchair
- Wigs (medically necessary)
- X-rays

WHAT'S NOT ELIGIBLE

Expenses that are not eligible for reimbursement from the General Purpose Health Care Flexible Spending Account and Limited Purpose Health Care Flexible Spending Account include, but are not limited to:

- Cosmetic treatment, surgery, or supplies, except to correct a congenital deformity or accidental injury
- Health Club Dues
- Maternity Clothes
- Physician's recommended weight loss. However, a weight-loss program that is determined to be Medically Necessary and for the treatment of a disease or ailment may be reimbursable under the Health Care Flexible Spending Account (medical necessity is determined by the attending Physician and the health plan covering the individual).
- Premiums or other charges for other health care policies, insurance plans, or COBRA premiums. For example, if Your Dependent has coverage under another group plan or if You have an individual plan, You cannot reimburse Yourself for contributions to these plans.
- Over-the-counter preparations such as vitamins, nutritional supplements, toiletries, or cosmetics.
- Social activities, such as dance lessons, even if recommended by a Physician.

Call customer service at the number on Your ID card for information on specific Over-the-Counter (OTC) drug and medicines eligible for reimbursement under the Health Care Flexible Spending Account and Limited Purpose Health Care Flexible Spending Account. Generally, items such as first aid cream, wart remover treatment, calamine lotion, bug bite medication, pain relievers, and cold medicine are eligible for reimbursement with proper receipts/documentation. Diet supplements, toiletries, and cosmetics are not eligible for reimbursement.

A more comprehensive discussion of expenses that may be considered eligible is contained in IRS Publication 502 entitled Medical and Dental Expenses. Copies of IRS Publication 502 are available at http://www.irs.gov/pub/irs-pdf/p502.pdf.

Important: Certain information in IRS Publication 502 may not be applicable, since some of the laws governing health care flexible spending accounts are different from the laws governing medical expense deductibility. For example, insurance premiums and certain long term care expenses are not eligible for reimbursement from the General Purpose Health Care Flexible Spending Account or the Limited Purpose Health Care Flexible Spending Account even though these expenses may qualify as deductible medical expenses as explained in IRS Publication 502. If You have any questions regarding what qualifies as an eligible General Purpose Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account expense, please contact UnitedHealthcare.

In the event of a conflict between this Plan Document and Summary Plan Description and applicable IRS rules, as amended, the IRS rules shall govern.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

The Dependent Care Flexible Spending Account allows You to use pre-tax dollars to pay for eligible dependent care expenses if You (or You and Your Spouse) need these services to allow You to work. **You are eligible to enroll if You have an eligible dependent and if You fall into one of the following categories:**

- You are a working single parent.
- You and Your Spouse both work.
- Your Spouse is a full-time student for at least five months of the Plan Year.
- Your Spouse is mentally or physically disabled and unable to care for him, herself, or Your dependent.
- Your Spouse is currently unemployed, but actively looking for work.

If You are divorced or separated and according to a written decree or agreement, You are the non-custodial parent, You may not use a Dependent Care Flexible Spending Account to pay for childcare expenses.

Eligible Dependents

Subject to the rule regarding non-custodial parents, eligible dependents for the purposes of this account **must be claimed as dependents on Your federal tax return and are either:**

- Under age 13, or
- Mentally or physically unable to care for himself or herself, regardless of age (this may include a disabled Spouse or older relatives).

Covered Dependent Care Flexible Spending Account Expenses

The types of care that can be reimbursed are subject to all provisions of IRS Publication 503 and currently include:

- Care at a licensed day care facility.
- Care at an unlicensed facility caring for less than seven people.
- Childcare expenses incurred by a Child's attendance at a Montessori school are reimbursable under this account as long as the school is pre-kindergarten.
- The childcare portion of kindergarten, if the provider is able to separate the costs between childcare and tuition. This is sometimes referred to as before-school or after-school care.
- In-home baby-sitting services.
- Day camp.
- After-school care.
- Practical nursing care for an adult.

Refer to IRS Publication 503 (Child and Dependent Day Care Expenses) for a complete list of eligible expenses. You can download a copy of IRS Publication 503 at http://www.irs.gov/pub/irs-pdf/p503.pdf.

In the event of a conflict between this Plan Document and Summary Plan Description and applicable IRS rules, as amended, the IRS rules shall govern.

If the dependent care provider is Your own Child or relative, the expenses are eligible for reimbursement only if the provider is at least age 19 before the end of the Plan Year in which claims are incurred and the Provider is not claimed as a dependent on Your income tax return. You are required to report the name, address, and Social Security number or Tax Identification number of Your dependent care provider on Your federal tax return (IRS Form 2441); otherwise, the amount of Your reimbursements will become taxable income and will be reported on Your W-2 form.

What's Not Eligible

You may **not** request reimbursement for the following expenses:

- Any amounts paid to provide food, clothing, or education.
- Services outside Your home at a camp where Your Child or disabled Spouse or dependent stays overnight.
- Transportation to and from the place where care is provided.
- Private school tuition expenses for dependents in first grade or above (after-school care is an eligible expense if this item is listed separately from tuition on Your bill).
- Private school tuition expenses below the first grade when the school can separate the cost of childcare. In this case, only the cost of childcare will be considered reimbursable.
- Training and travel expenses for the childcare provider.

Your Dependent Care Flexible Spending Account Contributions

The amount You can contribute to a Dependent Care Flexible Spending Account each year depends on Your family situation and tax filing status.

The annual maximums specified in the chart on the following page apply regardless of how many months You actually participate.

These maximums include any money You may have contributed during the Calendar Year to a Dependent Care Flexible Spending Account at a previous employer or that Your Spouse contributes to a Dependent Care Flexible Spending Account at his or her employer. The minimum contribution is $5 per paycheck or $120 per year whichever is more.

You also have the option to take a federal tax credit for dependent care expenses instead of using a Dependent Care Flexible Spending Account. Depending upon Your individual circumstances, it may be beneficial to take the tax credit rather than to participate in the Dependent Care Flexible Spending Account. You may want to consult Your tax advisor to determine which method is best for You.

The annual maximum reflected in the below chart apply regardless of how many months You actually participate in this Plan or another employer plan:

IF YOU ARE…	YOU MAY CONTRIBUTE UP TO…
A Working Single Parent	$5,000 Per Year
Married and Filing a Joint Tax Return & Your Spouse **Does Not** Have Access to a Dependent Care FSA	$5,000 Per Year
Married and Filing a Joint Tax Return & Your Spouse **Has** Access (Combined) to a Dependent Care FSA	$5,000 Per Year

Married and Filing Separate Tax Returns	$2,500 Per Year
Married and Your Spouse Earns Less Than $5,000 Per Year	Up To The Amount Of Your Spouse's Annual Income
Married to Another ACME Employee	$5,000 Per Year (Combined)

Health/Dependent Care FSA – Qualified Expenses & Reimbursement

There are several methods a Covered Person may pay for, or obtain reimbursement for qualified expenses

Health/Dependent Care FSA - Bank Issued FSA Debit MasterCard

Pay for qualified health expenses at the point of service/sale. Due to IRS rules, some purchases may require You to submit substantiation receipts to UnitedHealthcare.

Health/Dependent Care FSAs - Online Claim Submission

Access www.myuhc.com and submit reimbursement claim(s) online.

Health/Dependent Care FSA - Automatic Payment

To ease administration of Your claims, UnitedHealthcare has established relationships with MetLife Dental and Vision Service Plan (VSP). You may choose to have Your qualified UnitedHealthcare medical, dental, and vision claims will automatically be processed and reimbursed to You. Auto reimbursement is not established with Kaiser Permanente HMO Plans. If You do not want automatic reimbursement of Your qualified expenses, please access www.myuhc.com and "opt out." If You are enrolled in the HSA Medical Plan and the Limited Purpose Health Care FSA, it is recommended that You "opt out" of the auto reimbursement feature to prevent duplicate payments (HSA and FSA) for the same qualified service.

You may also have certain claims automatically reimbursed or submit a claim to be reimbursed from Your account. Claims must be for a minimum of $25 and are generally paid within three weeks of receipt.

Printed Claim Form

Forms are available on www.myuhc.com. Forms are also available on the ACME US Benefits Website.

FSA DEBIT MASTERCARD

You will be provided with a bank issued debit card that may be used to pay eligible expenses directly from Your General and Limited
Purpose Health Care FSA and/or Dependent Care FSA. With the debit card, You are able to make direct payments to qualified locations and can be used at any approved location that accepts MasterCard®. Using the debit card is voluntary. You will automatically receive two debit cards upon initial enrollment (e.g., new hire). Debit cards are mailed to Your home address on file approximately 10 – 15 business days after You submit Your ACME US Benefits elections.

Receiving Your FSA Debit MasterCard

Upon receipt of Your FSA Debit Card, please read the terms and conditions insert and sign the back of Your card. You may call the customer service number listed on the back of Your FSA Debit Card to order additional cards. New cards will not be issued each Calendar Year. Like a normal credit card - Your FSA Debit Card will be re-issued when Your card expires.

Activating Your FSA Debit MasterCard

If You choose to activate and use the FSA Debit MasterCard, You will need to call the toll-free number indicated on the sticker affixed to the card and follow the voice prompts to activate. The card will be ready to use one (1) business day following activation. Please plan accordingly.

If You choose not to activate and use the FSA Debit MasterCard – You can completely destroy and discard both cards. If You choose not to use the FSA Debit MasterCard – You will be required to pay for qualified expenses out-of-pocket and either receive reimbursement automatically (default payment method) – or submit a reimbursement claim online – or by mailing/faxing a printed form.
In addition to the FSA Debit MasterCard – there are several other options to submit a claim. Refer to "Flexible Spending Account (FSA)
- Claim Filing" and “Health/Dependent Care FSA – Automatic Payment.”

Qualified Debit Card Locations and Providers
The FSA Debit MasterCard may be used at any approved provider or merchant with a Point-of-Service (POS) bankcard terminal that accepts MasterCard® or Your debit card number can be entered online or on an order form, similar to using a credit card number. You can even use Your debit card to pay for a bill You receive in the mail if the merchant or provider accepts MasterCard®. Examples of qualified locations and providers include Hospitals, Physician and dental offices, vision care providers, retail pharmacy counters, and child and adult day care facilities. You may choose to use Your debit card for mail order prescriptions or for over-the-counter items by going to an online pharmacy such as Drugstore.com. Additionally, Your debit card can be used at participating retailers. Refer to "Retailers with Inventory Information Approval System (IIAS)."

Using Your FSA Debit MasterCard

In order to use the debit card, You will need to enter 'credit' on the POS bankcard terminal just as if You were purchasing an item using a credit card. Each time the card is used for payment, You will sign a receipt. Your Flexible Spending Accounts and card are regulated by the IRS; therefore, You should retain all itemized receipts generated from the debit card, because certain payments must be verified and UnitedHealthcare may request this receipt from You to ensure that payment was made for a qualified health care or dependent care expense. Credit card receipts that do not itemize expenses are not sufficient to verify payment. Amounts paid that cannot be verified may be considered taxable income to You.

Once You swipe Your FSA Debit MasterCard through the bankcard terminal, Your available benefit balance is verified. The card validates Your purchases real-time and automatically debits Your Flexible Spending Account based on the guidelines established by the IRS and the Plan (Note: Automatic debits apply to expenses associated with UnitedHealthcare, MetLife Dental, and VSP). A claim number is assigned to the transaction.

Debit cards are setup with “Pay and Chase” processing which allows You to use the debit card to “Pay” for medical, dental and vision services at the point of service or point of sale. The majority of debit card transactions are automatically substantiated through the system. Should a transaction require substantiation, the payment transaction will NOT be declined. Instead, You will receive a notice in the mail from UnitedHealthcare instructing You to submit receipt(s) to substantiate the claim.

If You do not submit necessary, documentation within 90 days, YOUR DEBIT CARD WILL BE SUSPENDED and You will not be able to use it until required substantiation action is taken.

Eligible Expenses Reimbursed through Your FSA Debit MasterCard
Your card can be used for certain qualified health and dependent care expenses. While the FSA Debit MasterCard transactions can be used for Copayments, Coinsurance, and Deductibles, the debit card or purchase transaction does not determine patient responsibility.

Partial Payment Authorization
Partial authorization capability allows You to use Your debit card with transactions amounts greater than the funds available in Your FSA for a portion of the transaction at providers or merchants that accept partial authorization. For example, if You purchase an item that costs $20 and You only have $10 remaining in Your account, the balance of

$10 will be authorized towards the purchase and You are responsible for paying the remaining balance of $10 with another form of payment. Note: not all providers or merchants accept partial authorization.

Retailers with Inventory Information Approval System (IIAS)
IRS regulations allow retailers to comply with IRS Inventory Information Approval System (IIAS) swipe technology as a method to identify and substantiate eligible pharmacy health care expenses, pursuant to Section 213(d) of the Internal Revenue Code. The IIAS allows You to use Your debit card to pay for 213(d) eligible health care expenses without having to provide any additional documentation or request reimbursement after a purchase is made, as transactions will be verified at the point of sale and payment will be made right from Your Health Care FSA. Additionally, IIAS compatibility allows You to use Your debit card at participating retailers to pay for both ineligible expenses and eligible health care expenses on the same transaction with eligible health care expenses being approved via the debit card and remaining ineligible expenses may be paid using another form of payment. When You use Your card at participating retailers, eligible health care expenses will be identified and noted on Your receipt. You will not have to submit receipts for reimbursement as long as the purchases are made at a participating retailer and You use Your debit card. IRS guidelines still require You to save Your itemized receipts as part of Your tax records. You can see a full list of participating retailers at www.sig-is.org. If You go to a non-participating retailer, You can still buy eligible health care expenses that don't provide itemized sales receipts, however You will need to pay using another form of payment, and then submit receipts for reimbursement as described under the Filing a Flexible Spending Account Claim section.

USING YOUR FSA

Use It or Lose It (Dependent Care FSA)
According to the IRS' “Use it or Lose it” rule, if Your eligible dependent care expenses for the Calendar Year (January 1 – December 31) is less than Your account balance You will forfeit the unused balance. Your unused balance cannot be paid back to You or carry over into the next year. Plan Your expenses carefully! All funds left in Your Dependent Care FSA at the end of the Plan Year will be forfeited. You may submit claims until March 31 of the following year for expenses incurred during the preceding Plan Year ending December 31st. ACME may use Flexible Spending Account forfeitures in accordance with IRS regulations. Currently, ACME uses forfeitures to offset administrative costs of the Plan.

Carryover Provision
You may carry over up to $610 of Your unused Health Care FSA money into the 2024 Plan Year ($640 into 2025). This means that any unused balance (up to $610) can be used to pay for Eligible Expenses incurred in subsequent years. The carryover applies to the General Purpose and Limited Purpose Health Care FSA only. It does **NOT** apply to Dependent Care FSA.

FSA or Tax Deduction, Not Both
You may not claim a tax deduction for eligible health care expenses reimbursed through a pre-tax Flexible Spending Account. Please consult with Your tax advisor for details.

FSA or HSA, Not Both
You may pay for Eligible Expenses using either Your HSA or Health Care FSA. You may not obtain reimbursement from both accounts for the same expense.

General Purpose or Limited Purpose (Not Both)
If You enroll in the HSA Medical Plan, You may enroll in the Limited Purpose Health Care FSA. You may not enroll in the General Purpose Health Care FSA. If You waive medical coverage and are enrolled in Your Spouse or Qualified Domestic Partner’s IRS qualified HDHP with HSA and would like to elect the Limited Purpose Health Care FSA, please contact ACME US Benefits.

Plan Year Elections

Once You enroll in a pre-tax Flexible Spending Account, You may only change Your election during the Calendar Year if You have a Qualified Family Status Change and change your election prior to November 15. If You are hired after January 1, Your enrollment year is effective from Your date of hire until December 31 of that same year. This means that Your "annual" contribution is only for those covered expenses that were incurred from Your date of hire through December 31 of that same year. Expenses incurred prior to Your enrollment in the Plan are not reimbursable.

Open Enrollment

If You wish to participate in the Health and/or Dependent Care FSA during the following Calendar Year, **You must re-enroll during Open Enrollment** to elect Your annual contribution amount for the following Calendar Year. Your FSA contribution elections do not carry over to the next Calendar Year.

Increasing/Decreasing Elections

If You increase Your Health Care FSA election (annual contribution amount) as the result of a Qualified Family Status Change, the amount of the increase may only be used to cover expenses incurred on or after the effective date of the Qualified Family Status Change. You may not decrease Your Dependent Care FSA election (annual contribution amount) below the amount that You have already contributed year-to-date.

Claim Run-out Period

You may submit claims until March 31 of the following year for expenses incurred during the preceding Calendar Year ending December 31 (the run-out period). Claims received after March 31 will not be eligible for reimbursement.

Monthly Health Statements and Yearly Statement

Explanation of Benefits (EOBs) will not be issued for card transactions. Instead, You will receive monthly health statements and a Flexible Spending Account yearly statement, which will include Your card activity. You will also be able to view card transactions on www.myuhc.com. If You note a discrepancy on the monthly health statement or Flexible Spending Account yearly statement, call the number on the back of Your debit card to resolve the issue.

Contact a Customer Care Professional

Simply call the toll-free number 1-866-755-2648, available 24 hours a day to:

- Order additional cards
- Report a lost or stolen card
- Get answers concerning Eligible Expenses or Your account balance
- Obtain help regarding substantiation of debit card expenses

EFFECTIVE DATE AND COVERAGE PERIODS

Your benefits begin on Your enrollment effective date (e.g., new hire date or January 1 if enrolled during Open Enrollment). This means that Your "annual" reimbursement account contribution covers expenses incurred on Your effective date through December 31. Should You become ineligible prior to the end of the year (e.g., termination), expenses must be incurred prior to Your ineligibility date.

If You change Your General or Limited Purpose Health Care Flexible Spending Account election because of a Qualified Family Status Change, You will be treated as having two separate coverage periods:

1. The first coverage period starts on the earlier of January 1 (or Your initial enrollment date). The first coverage period ends on the day before the effective date of Your Qualified Family Status Change.
2. The second coverage period starts on the effective date of Qualified Family Status Change. The second coverage period ends on the earlier of the date You cease participation in the Plan - or December 31. If You increase Your Health Care FSA election (annual contribution amount) as the result of a Qualified

Family Status Change, the amount of the increase may only be used to cover expenses incurred during the second coverage period.

WHEN COVERAGE ENDS

If Your coverage ends during the Plan Year because Your employment or eligibility for coverage ends and You are rehired or return to regular status during the same Plan Year, coverage may be reactivated as follows:

- If You are rehired within 30 days of the date coverage had ended, You will resume participation by continuing Your
  original elections for the remainder of the Plan Year on a pro rata basis (You are bound by Your original elections).
- If You are rehired after 30 days have elapsed, You may make a new election (You are not bound by Your original elections). Note: If You are rehired after 30 days have elapsed, claims incurred during Your gap in service will not be eligible for reimbursement (because You were not an active participant in the Plan during Your gap).
- If Your coverage ended during Your leave of absence and You return to work (working 20 or more hours per week) within the same calendar year that Your coverage ended, and before November 15, Your coverage will automatically be reinstated to Your most recent benefit elections. If You were enrolled into a Flexible Spending Account (FSA) and/or Healthcare Savings Account (HSA), contact ACME US Benefits to have Your per pay check contribution amount recalculated to meet Your elected goal amount. If You return to work after November 15th, Your FSA and/or HSA will not be reinstated for the remainder of the calendar year.
- If Your coverage ended during Your leave of absence and You return to work (working 20 or more hours per week) in a
  different calendar year from when Your coverage ended, You will need to re-elect participation in a Flexible Spending Account (FSA) within 31 days from Your return to work date. If You fail to make a FSA election, You will not be enrolled in a FSA.

If Your employment with ACME ends, Your payroll contributions to the Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account will stop. You will be able to file claims from Your account balance for eligible health care expenses You incur before Your employment ends, up to the annual amount You had elected to deposit, less prior reimbursements.

You also have the option under COBRA to continue Your participation in the Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account (making contributions and filing claims for expenses incurred for the rest of the year), but Your contributions must be made with after-tax dollars. Flexible Spending Account coverage also will end if You do not make a required contribution to Your Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account.

If You take an unpaid family care leave, Your participation in the Health Care Flexible Spending Account or Limited Purpose Health
Care Flexible Spending Account will continue up to 30 days and your contributions will cease. To continue participation in the Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account beyond 30 days, You may elect COBRA. COBRA election documents will automatically be mailed to You if/when You become eligible.

For the Dependent Care Flexible Spending Account, You can file claims for reimbursement of eligible Dependent Care expenses incurred up until the end of the Calendar Year even after Your termination of employment with ACME, but You cannot be reimbursed for claims that exceed the balance in Your Account at the time of Your claim.

Rules and covered expenses for the Health Care Flexible Spending Account, the Limited Purpose Health Care Flexible Spending Account, and the Dependent Care Flexible Spending Account are highly regulated by the Internal Revenue Service. For details on covered expenses, please consult UnitedHealthcare.

Read the following sections for additional rules and guidelines that apply to each specific account.

FLEXIBLE SPENDING ACCOUNT - AFFECT YOUR OTHER BENEFITS

Although You are converting part of Your pay into pre-tax dollars, this does not reduce Your base pay for purposes of overtime pay, pay increases or for calculating other benefit coverage based on pay, such as Your Employee life insurance, AD&D or LTD coverage.

However, because You do not pay Social Security taxes on the money You contribute to Flexible Spending Accounts, Your Social Security benefits could be affected. The effect would depend on many factors, such as Your pay, the amount You contribute to the accounts, and the number of years You participate in these accounts.

FLEXIBLE SPENDING ACCOUNT (FSA) - CLAIM FILING

During the year, whenever You have an eligible expense, You can file for reimbursement from the appropriate pre-tax Flexible Spending Account. Expenses are incurred at the time the service is furnished and not when You receive a bill, are charged, or pay for the service. You may file as often as You wish; however, Your request must be for a minimum of $25. The $25 minimum does not apply for claims submitted during the period of January 1 to March 31 for expenses incurred during and for the prior Plan Year. The amount available for reimbursement under the General and Limited Purpose Health Care FSA is the annual amount You elected (plus any carryover amount up to $610 for 2024), reduced by prior reimbursements made during the Plan Year. The amount available for reimbursement under the Dependent Care Flexible Spending Account is limited to the actual amounts credited to Your account (i.e., the year-to-date amount that has been deducted from Your pay for reimbursement of dependent care expenses for the Plan Year, reduced by prior reimbursements made during the Plan Year). You may submit a claim for reimbursement online at www.myuhc.com. Printed reimbursement claim forms are also available on www.myuhc.com and the ACME US Benefits Website.

Claims Deadline: For any given Plan Year, You may submit claims for that Plan Year at any time during the Plan Year, and through
March 31 following the end of a Plan Year. **Claims MUST BE received on or before March 31 to be processed. Claims RECEIVED AFTER March 31 will no longer be eligible for reimbursement.** However – any unused General or Limited Purpose Health Care FSA contributions not to exceed $610 will carry over into 2024 ($640 for 2025) and can be used for current and future year reimbursement of eligible expenses.

Claim forms can be mailed or faxed to UnitedHealthcare. Address and fax number is noted on the claim form.

For reimbursement from Your Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account, You will need to include an invoice or receipt from Your Provider or Hospital, or an Explanation of Benefits (EOB). For reimbursement from Your Dependent Care Flexible Spending Account, You will need to include a receipt or bill from Your dependent care provider with Your provider's tax identification number written on it. If Your dependent care provider (babysitter, daycare, etc.) does not have a tax ID number, You may submit a signed letter from the provider validating the service dates and charges rendered.

Each time You file a claim and receive reimbursement, You will receive an Explanation of Payment (EOP). Your EOP will list the total amount You elected to contribute, Your contributions to date, any reimbursements You have already received, and Your current account balance. In addition, every participant will receive a summary account statement to remind You to file claims before the end of the claim run out period (March 31 for expenses incurred through December 31 of the previous Plan Year).

Reimbursements are issued as a paper check (with Your Explanation of Payment) unless You elect to have Your reimbursement made directly to Your bank account. If You wish to receive reimbursements, using Electronic Funds Transfer (EFT), You must select this option and provide applicable bank account information. Election of EFT is completed online at www.myuhc.com.

Within 30 days after UnitedHealthcare's receipt of a claim for reimbursement, You will receive either the reimbursement or a notice that Your claim has been denied.

HEALTH CARE FSA – APPEAL PROCESS

Initial Determination

If Your claim is denied for reimbursement, You will receive a written notice from UnitedHealthcare within 30 days of receipt of the claim, as long as all needed information was provided with the claim. UnitedHealthcare will notify You within this 30-day period if additional information is needed to process the claim, and may request a onetime extension not longer than 15 days and pend Your claim until all information is received.

Once notified of the extension You then have 45 days to provide this information. If all of the needed information is received within the 45-day period and the claim is denied, UnitedHealthcare will notify You of the denial within 15 days after the information is received. If You do not provide the needed information within the 45-day period, Your claim will be denied.

A denial notice will explain:

- The reason(s) for the denial and the Plan provisions on which the denial is based;
- A description of any additional information necessary for You to perfect Your claim, why the information is necessary, and Your time limit for submitting the information;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of Your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination after completion of all levels of review required by the Plan; and
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol or other similar criterion was relied upon in denying the claim, and that a copy of such rule, guideline, protocol, or other similar criterion will be provided to the claimant free of charge upon request; and
- If the denial is based on a medical necessity or experimental treatment or similar Exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, or a statement that such explanation will be provided to You free of charge upon request.

Request For Appeals

If You have a question or concern about a claim reimbursement determination, You may informally contact a UnitedHealthcare Customer Service representative before requesting a formal appeal. The Customer Service telephone number is 866.672.2511. If the Customer Service representative cannot resolve the issue to Your satisfaction, You may request a formal appeal as described below.

If You wish to request a formal appeal of a denied claim for reimbursement, You should contact Customer Service to obtain the UnitedHealthcare address where the appeal should be sent. Your appeal should be submitted in writing to that address and should include Your name and identification number, a description of the claim determination that You are appealing, the reason You believe Your claim should be reimbursed, and any written information to support Your appeal.

If Your claim for reimbursement is denied, in whole or in part, You (or Your authorized representative), may appeal the denial by submitting a written request for review of the claim to UnitedHealthcare within 180 days after receiving written notice of the denial. A request for review must be in writing and shall set forth all of the grounds upon which it is based, all facts in support thereof, and any other matters that You deem pertinent.

If You (or Your authorized representative) request an appeal of a denied claim, the following procedures shall apply:

- You (or Your authorized representative) shall have the opportunity to submit written comments, documents, records, and other information relating to the claim; and
- You (or Your authorized representative) shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to Your claim (other than legally or medically privileged documents); and
- The appeal shall take into account all comments, documents, records, and other information submitted by You relating to the claim, without regard to whether such comments, documents, records, and other information were submitted or considered in the initial benefit determination; and
- The appeal shall not afford deference to the initial claim denial and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of that individual; and
- In deciding an appeal that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental, Investigational or Unproven, or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and such health care professional shall not be the individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal (nor the subordinate of such individual); and
- UnitedHealthcare shall, upon request, provide for the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

For purposes of the Appeals process, the term "Relevant" means a document, record, or other information regarding Your claim for a Plan benefit if such document, record, or other information:

- Was relied upon in making the benefit determination; or
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; or
- Demonstrates compliance with the administrative processes and safeguards required pursuant to the ERISA claims regulations; or
- Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The first level appeal will be conducted and You will be notified by UnitedHealthcare of the decision in writing within 30 days from receipt of a request for appeal of a denied claim.

If You are not satisfied with the first level appeal decision, You have the right to request a second level appeal from the Plan Sponsor. Your second level appeal request must be submitted within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and You will be notified by the Plan Sponsor of the decision in writing within 30 days from receipt of a request for a second level appeal.

If Your claim is again denied, either at the first or second level of appeal, You shall be notified in writing. Such written notice shall set forth, in a manner calculated to be understood by You, the following information:

- The specific reason(s) for the denial; and
- Reference to the specific Plan provision(s) on which the denial is based; and
- A statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to Your claim for reimbursement; and
- A statement of Your right to bring an action under Section 502(a) of ERISA after Your claim is denied after completion of all levels of review required by the Plan; and
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol or other similar criterion was relied upon in denying the claim, and that a copy of such rule, guideline, protocol, or other similar criterion will be provided to You free of charge upon request; and
- If the denial is based on a medical necessity or experimental treatment or similar Exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, or a statement that such explanation will be provided to You free of charge upon request.

Other important information regarding Your Health Care Flexible Spending Account Appeals (General and Limited Purpose):

- ❖ Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- ❖ On each level of appeal, the claims reviewer will review relevant information that You submit even if it is new information; and
- ❖ You cannot file suit in federal court until You have exhausted these appeals procedures.
- ❖ The Plan Sponsor has the exclusive right to interpret and administer the Plan, and these decisions are conclusive and binding.

DEPENDENT CARE FSA – APPEAL PROCESS

Initial Determination

If Your claim is denied for reimbursement, You will receive a written notice from UnitedHealthcare within 30 days of receipt of the claim, as long as all needed information was provided with the claim. UnitedHealthcare will notify You within this 30-day period if additional information is needed to process the claim, and may request a onetime extension not to exceed 15 days and pend Your claim until all information is received.

Once notified of the extension You then have 45 days to provide this information. If all of the needed information is received within the 45-day period and the claim is denied, UnitedHealthcare will notify You of the denial within 15 days after the information is received. If You do not provide the needed information within the 45-day period, Your claim will be denied.

A denial notice will explain the reason for the denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Request For Appeals

If You have a question or concern about a claim reimbursement determination, You may informally contact a UnitedHealthcare Customer Service representative before requesting a formal appeal. The Customer Service telephone number is 866.672.2511. If the

Customer Service representative cannot resolve the issue to Your satisfaction, You may request a formal appeal as described below.

If You wish to request a formal appeal of a denied claim for reimbursement, You should contact Customer Service to obtain the UnitedHealthcare address where the appeal should be sent. Your appeal should be submitted in writing to that address and should include Your name and identification number (for the purpose of these Flexible Spending Accounts, Your identification number is Your Social Security number), a description of the claim determination that You are appealing, the reason You believe Your claim should be reimbursed, and any written information to support Your appeal. Your first appeal request must be submitted in writing to UnitedHealthcare within 180 days after You receive the denial.

A qualified individual who was not involved in the initial benefit decision being appealed will be designated to decide the appeal. Upon request and free of charge, You have the right to reasonable access to and copies of all documents, records, and other information Relevant to Your claim for reimbursement.

The first level appeal will be conducted and You will be notified by UnitedHealthcare of the decision in writing within 30 days from receipt of a request for appeal of a denied claim. If You are not satisfied with the first level appeal decision, You have the right to request a second level appeal from the Plan Sponsor. Your second level appeal request must be submitted in writing to the Plan Sponsor within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and You will be notified by the Plan Sponsor of the decision in writing within 30 days from receipt of a request for a second level appeal.

The Plan Sponsor has the exclusive right to interpret and administer the Plan, and these decisions are conclusive and binding.

Group Term Life and Accidental Death and Dismemberment Insurance

This section of the Plan document and Summary Plan Description (SPD) summarizes the key provisions of the group term life and accidental death & dismemberment (AD&D) insurance plans.

For complete information on benefits and provisions of the life and accidental death & dismemberment (AD&D) insurance plans please refer to the official Certificate of Coverage issued by MetLife. Should the information contained in the Certificate of Coverage issued by MetLife or, any summary of material modifications (SMM) issued by MetLife differ from this Plan document and Summary Plan Description (SPD), the Certificate of Coverage issued by MetLife will govern and overrule any information contained in this Plan Document and SPD. This Plan document and SPD and the Certificate of Coverage issued by MetLife should be read and kept together.

GROUP TERM LIFE INSURANCE

Group Term Life Insurance provides Your named beneficiary benefits in the event of Your death. You are required to elect group term life insurance coverage. You have a choice of pre-tax and after-tax life insurance coverage options:

Life Insurance – Pre-Tax Options

These options allow You to pay for coverage using pre-tax dollars. The maximum coverage amount is $50,000.

- $10,000
- $50,000 (Maximum)

Life Insurance – After-Tax Options

Six coverage options allow You to pay for coverage using after-tax dollars. Your coverage options are multiples of Your Annual Benefits Compensation (1 – 6 times) up to the maximum coverage amount of $2,500,000 (see below).

- One Times (1x)
- Two Times (2x)

- Three Times (3x)
- Four Times (4x)
- Five Times (5x)
- Six Times (6x)

The combined pre-tax ($50,000) and after-tax ($2,500,000) maximum life insurance amount is $2,550,000. If You are a newly eligible Employee making Your first election You may choose any life insurance amount (up to the maximum) without medical review.

In general, death benefits received are not taxable.

Life Insurance – Minimum Required Coverage

When You make Your initial election You are required to elect at least the Minimum Required Coverage:
- Pre-Tax option of $10,000, or
- After-Tax option equal to one times (1x) Your Annual Benefits Compensation

Important Note: If You do **NOT** make an initial life insurance coverage election, You will automatically be enrolled in the Default Coverage which is the pre-tax coverage amount of $10,000.

For more information, please see the Minimum Required Coverage and Default Coverage sections of this document.

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Group accidental death & dismemberment (AD&D) insurance provides benefits in the event You die as a result of an accident. It also provides benefits in the event You experience loss of use or total loss of certain parts of the body due to an accident. Additional benefit provisions include the following benefit payments:

- Payment for using air bags and seat belts
- Payment if loss of life occurs while on a common carrier
- Payment to cover eligible childcare center expenses
- Education tuition coverage for surviving Spouse (or Qualified Domestic Partner) and Children
  Coverage for charges related to Hospitalization

As with life insurance coverage described in "Group Term Life Insurance," You are required to elect accidental death & dismemberment (AD&D) coverage.

The AD&D plan design is similar to the life insurance plan design described in "Group Term Life Insurance," except that You purchase Your AD&D coverage using pre-tax dollars. Your AD&D coverage election can be the same (or different) as Your life insurance election. Your pre-tax AD&D coverage options are:

AD&D- Pre-Tax Options

These options allow You to pay for coverage using pre-tax dollars. The maximum AD&D insurance amount is $2,000,000.

- $10,000
- $50,000
- A multiple of Your Annual Benefits Compensation (1 – 6 times)

AD&D – Minimum Required Coverage

When You make Your initial election You are required to elect at least the Minimum Required Coverage of $10,000 (pre-tax).

In general, AD&D benefits received are not taxable.

Important Note: If You do **NOT** make an initial AD&D insurance coverage election, You will automatically be enrolled in the Default Coverage which is the pre-tax coverage amount of $10,000. For more information, please see the Minimum Required Coverage and Default Coverage sections of this document.

LIFE INSURANCE AND AD&D - COVERAGE CHANGES

After You make Your initial election (e.g., new hire election), You can make changes to Your Life and AD&D insurance coverage during Open Enrollment and if You have a Qualified Family Status Change that permits Life/AD&D changes.

You may increase Your Life and AD&D insurance coverage by one level (without medical review) and decrease Your coverage by any level. During Open Enrollment and permissible Qualified Family Status Change, You may not increase Your coverage by more than one level. If You would like to increase Your coverage by more than one level You will need to increase Your coverage during multiple Open Enrollment periods and/or permissible Qualified Family Status Changes. Refer to "Enrollment Information" for additional information.

LIFE INSURANCE AND AD&D - BENEFICIARY DESIGNATION

You are required to make Your group term life and accidental death & dismemberment (AD&D) beneficiary designation(s) on the ACME US Benefits Enrollment System. To ensure accuracy, it is recommended that You periodically review Your beneficiaries (e.g., during each Open Enrollment).

Long Term Disability Insurance

This section of the Plan document and Summary Plan Description (SPD) summarizes the key provisions of the group long term disability insurance plan.

For complete information on benefits and provisions of the long term disability insurance plan, please refer to the official Certificate of Insurance issued by The Hartford. Should the information contained in the Certificate of Insurance issued by The Harford or any summary of material modifications (SMM) issued by The Hartford differ from this Plan document and Summary Plan Description (SPD), the Certificate of Insurance issued by The Hartford will govern and overrule any information contained in this Plan document and SPD. This Plan document and SPD and the Certificate of Insurance issued by The Hartford should be read and kept together.

Long term disability benefits are paid to You when You have been totally disabled for a certain period of time. You have a choice of the following long term disability coverage levels. You may choose to purchase coverage using pre-tax or aftertax dollars.

- 50% of Your Annual Benefits Compensation, up to a maximum monthly benefit of $12,000
- 66 2/3 % of Your Annual Benefits Compensation, up to a maximum monthly benefit of $18,500

LONG TERM DISABILITY - PRE-TAX & AFTER-TAX OPTIONS

If You enroll in one of the pre-tax options, Your cost will be deducted before any taxes are applied; however, should You file a claim for benefits, all benefits payable will be taxable, and a Form 1099 will be issued in January of each year by the Hartford. If You enroll in one of the after-tax options, Your cost will be deducted after taxes have been applied. Should You file a claim for benefits, all benefits payable will be non-taxable (subject to a three-year look back).

Long Term Disability – Three-Year Look Back

If, during the year of Your disabling event, You paid for Your long term disability insurance in part with pre-tax contributions and with after-tax contributions, a portion of the long term disability benefits You receive will be taxable. An IRS rule known as the "threeyear look back" will be used to determine the tax treatment of Your long term disability benefits. Under this rule, the taxable amount of Your long term disability benefit payments will correspond

to the pro-rata portion of long term disability premiums paid by ACME for all Employees, including aggregate pre-tax payroll deduction contributions, during the three policy years before the Calendar Year in which You become disabled. Please refer to the Certificate of Insurance issued by The Hartford for more information.

LONG TERM DISABILITY - MINIMUM REQUIRED COVERAGE

When You make Your initial election, You are required to elect at least the Minimum Required Coverage:

- 50% of Your Annual Benefits Compensation (pre-tax) or
- 50% of Your Annual Benefits Compensation (after-tax)

Important Note: If You do **NOT** make an initial long term disability insurance coverage election, You will automatically be enrolled in the Default Coverage which is the pre-tax 50% of Your Annual Benefits Compensation coverage option. For more information, please see the Minimum Required Coverage and Default Coverage sections of this document.

Medicare & ACME's Medical Plans

This section describes how Medicare coordinates with ACME's Medical Plans. Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.
If you are eligible for or enrolled in Medicare, please read the following information carefully.

ELIGIBILITY

Unless You have a qualifying disability or end stage renal disease[12] You become Medicare eligible and have the opportunity to enroll in Medicare beginning at age 65. Medicare's Initial Enrollment Period (IEP) begins several months prior to Your 65th birthday.

If You are an active ACME Employee who is eligible but not enrolled in Medicare, You may:

- Defer Medicare enrollment and remain covered by ACME's UnitedHealthcare (UHC) (or Kaiser Permanente HMO) Medical Plan,
- Enroll in Medicare and remain covered by ACME's UnitedHealthcare (UHC) (or Kaiser Permanente HMO) Medical Plan, or
- Enroll in Medicare and drop ACME's UnitedHealthcare (UHC) (or Kaiser Permanente HMO) Medical Plan coverage pursuant to a Qualified Family Status Change.

If You are an active ACME Employee and enrolled in Medicare, You may:

- Remain covered by ACME's UnitedHealthcare (UHC) (or Kaiser Permanente HMO) Medical Plan, or
- Waive ACME's UnitedHealthcare (UHC) (or the Kaiser Permanente HMO) Medical Plan coverage during Open Enrollment.

If You remain covered by ACME's UHC (or Kaiser Permanente HMO) Medical Plan, ACME's UHC (or Kaiser Permanente HMO) Medical Plan will be the primary payer for purposes of claims processing and payment. Medicare will be the secondary payer (pays after the primary payer). Refer to "Coordination of Benefits – UnitedHealthcare Medical Plans" (or the Kaiser Permanente HMO Medical Plan Evidence of Coverage) for more information regarding primary and secondary payers.

[12] Medicare is health insurance for individuals age 65+, for individuals under age 65 with certain disabilities, and individuals, of any age, with End-Stage Renal Disease.

If Your Spouse or Qualified Domestic Partner becomes eligible and enrolls in Medicare, he or she will remain covered by ACME's UHC (or Kaiser Permanente HMO) Medical Plan, unless You remove him or her as Your covered Dependent pursuant to a Qualified Family Status Change.

If You are an active ACME Employee and Your Spouse/Qualified Domestic Partner, or Child is disabled and enrolled in Medicare, ACME's UHC (or Kaiser Permanente HMO) Medical Plan will be the primary payer for purposes of claims processing and payment. Medicare will be the secondary payer (pays after the primary payer). Except if you are enrolled in the HSA Plan, then your Qualified Domestic Partner only, will have Medicare as the primary payer, the ACME HSA Plan will be secondary.

Medicare – Health Savings Accounts (HSAs)

Enrollment in any part of Medicare (even if automatically enrolled in Part A due to receiving Social Security benefits) disqualifies You from opening and contributing to a Health Savings Account (HSA). Although You are not able to contribute to Your HSA, You may still access and use Your existing HSA funds to pay for qualified expenses. Note: For more information regarding HSA eligibility, visit
ACME's HSA Resource Center and/or refer to "HSA Medical Plan."

Medicare – Coordination of Benefits

In some situations, Medicare may be primary to ACME's UHC (or Kaiser Permanente HMO) Medical Plans. If You qualify for Medicare coverage to be the primary payer, You must enroll and maintain coverage under both Medicare Part A and Part B. If You do not, and if ACME's UHC (or Kaiser Permanente HMO) Medical Plan is the secondary payer, benefits will be paid under ACME's UHC (or Kaiser Permanente HMO) Medical Plan as if You were covered under both Medicare Part A and Part B, thus increasing Your out-of-pocket costs.

If You are enrolled in a Medicare Advantage Plan (Medicare Part C) on a primary basis, You must follow all plan rules that require You to seek services from that plan's participating providers. When ACME's UHC (or Kaiser Permanente HMO) Medical Plan is the secondary payer, UnitedHealthcare (or Kaiser Permanente) will pay benefits available to You under ACME's UHC (or Kaiser
Permanente HMO) Medical Plan as if You had followed all rules of the Medicare Advantage Plan. If ACME's UHC (or Kaiser Permanente HMO) Medical Plan is the secondary payer and You do not follow the rules of the Medicare Advantage Plan, You will incur a larger out-of-pocket cost.

When Medicare is the primary payer under ACME's UHC (or Kaiser Permanente HMO) Medical Plan, UHC (or Kaiser Permanente) will reduce its benefits as described below:

- Medicare benefits are determined as if You were covered under Medicare Part A and Part B.
- The person is enrolled in a Medicare Advantage Plan receives non-covered Non-Network services because the person did not follow the rules of that plan — Medicare benefits are determined as if the services were covered under Medicare Part A and Part B.
- The person received services from a Provider who has elected to opt out of Medicare — Medicare benefits are determined as if the services were covered under Medicare Part A and Part B and the Provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in a Veterans Administration facility or other facility of the federal government — Medicare benefits are determined as if the service were provided by a non-governmental facility and covered under Medicare.
- The person is enrolled under a plan with a Medicare Medical Savings Account — Medicare benefits are determined as if the person were covered under Medicare Part A and Part B.

Kaiser Permanente HMO Plans

If You are enrolled in one of the ACME Kaiser Permanente HMO Plans and enrolled in Medicare, Kaiser Permanente will coordinate benefits with the Medicare coverage under Medicare rules. For additional information, please contact Kaiser Permanente directly and/or refer to the applicable Evidence of Coverage.

Other Important UnitedHealthcare Medical Plan Information

REVIEW AND DETERMINE BENEFITS IN ACCORDANCE WITH UNITEDHEALTHCARE REIMBURSEMENT POLICIES

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to Provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other Providers in UnitedHealthcare's Network through UnitedHealthcare's Provider website. Network Physicians and Providers may not bill You for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, Non-Network Providers are not subject to this prohibition, and may bill You for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for Yourself or to share with your Non-Network Physician or Provider by going to www.myuhc.com or by calling the telephone number on Your ID card.

UnitedHealthcare may apply a reimbursement methodology established by OptumInsight and/or a third party vendor, which is based on CMS coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use comparable methodology(ies).
UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group.
Refer to
UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable methodology.

UnitedHealthcare will apply a multiple procedure payment reduction when multiple procedures are performed on the same day in accordance with its policies.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these Coordination of Benefit (COB) rules and to determine benefits payable under the UnitedHealthcare Medical Plans and other coverage plans. UnitedHealthcare may obtain the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining Benefits payable under the UnitedHealthcare Medical Plans and other coverage plans covering the person claiming benefits.

UnitedHealthcare need not tell, or get the consent of, any person to do this. Each person claiming benefits under the UnitedHealthcare Medical Plans must give ACME or UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If You do not provide ACME or UnitedHealthcare the information needed to apply these rules and determine the benefits payable, Your claim for benefits will be denied.

PAYMENTS MADE

A payment made under another coverage plan may include an amount that should have been paid under the UnitedHealthcare Medical Plans. If it does, UnitedHealthcare may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under the UnitedHealthcare Medical Plans. UnitedHealthcare will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

INCENTIVES TO YOU

Sometimes You may be offered coupons, enhanced benefits, or other incentives to encourage You to participate in various wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a nonUnitedHealthcare entity. The decision about whether or not to participate is Yours alone, but ACME recommends that You discuss participating in such programs with Your Physician. These incentives are not benefits and do not alter or affect Your benefits. You may call the number on Your ID card if You have any questions.

REBATES AND OTHER PAYMENTS

ACME and UnitedHealthcare may receive rebates for certain drugs that are administered to You in a Physician's office, or at a
Hospital or Alternate Facility. This includes rebates for those drugs that are administered to You before You meet your Annual Deductible. ACME and UnitedHealthcare may pass a portion of these rebates on to You. When rebates are passed on to You, they may be taken into account in determining Your Copays and/or Coinsurance.

RIGHT OF RECOVERY

If the amount of the payments UnitedHealthcare made is more than UnitedHealthcare should have paid under the Plan,
UnitedHealthcare may recover the excess from one or more of the persons UnitedHealthcare have paid or for whom UnitedHealthcare have paid; or any other person or organization that may be responsible for the benefits or services provided for You. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

IF YOU ARE INJURED THROUGH SOMEONE ELSE’S FAULT

A third party may be financially responsible if You incur medical expenses because of a negligent action by an individual, company, corporation, or government agency. Automobile accidents and injuries suffered on another person’s property are examples of such situations. Because collecting this money can take several months, the UnitedHealthcare Medical Plans may pay Your Covered Charges if You agree to the following in writing:

- To pay ACME’s claims administrator, UnitedHealthcare, and UnitedHealthcare consents, up to the amount of benefits received under the UnitedHealthcare Medical Plan (subject to applicable law) if any damages are collected, or
- To provide UnitedHealthcare with a lien for benefit paid. This lien may be filed with the third party, his or her agent, or a court, which has jurisdiction in the matter.

SUBROGATION AND REIMBURSEMENT

The Plan has a first right to subrogation and reimbursement. References to “You” or “Your” in this Subrogation and Reimbursement section shall include You, Your estate and Your heirs and beneficiaries unless otherwise stated. Subrogation applies when the Plan has paid benefits on Your behalf for a sickness or injury for which a third party is

alleged to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that You may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the sickness or injury for which any third party is considered responsible.

Subrogation – Example

Suppose You are injured in a car accident that is not Your fault, and You receive benefits under the Plan to treat Your injuries. Under subrogation, the Plan has the right to take legal action in Your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a sickness or injury for which

You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any benefits You received for that sickness or injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement – Example

Suppose You are injured in a boating accident that is not Your fault, and You receive benefits under the Plan as a result of Your injuries. In addition, You receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Plan 100% of any benefits You received to treat Your injuries.

Third Parties

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages;
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages;
- The Plan Sponsor in a workers' compensation case or other matter alleging liability;
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators;
- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to a sickness or injury You allege or could have alleged were the responsibility of any third party; and Any person or entity that is liable for payment to You on any equitable or legal liability theory.

Your Subrogation and Reimbursement Responsibilities

As a condition of receiving benefits under the Plan, You and/or Your covered Dependent (the Covered Person) agree to the following:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
    - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts which caused benefits to be paid or become payable;
    - Providing any relevant information requested by the Plan; ○ Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;
    - Responding to requests for information about any accident or injuries; ○ Making court appearances;
    - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses; and

- Complying with the terms of this section.

- Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate Your benefits, deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold which should have been returned to the Plan.
- The Plan has a first priority right to receive payment on any claim against any third party before You receive payment from that third party. Further, the Plan's first priority right to payment is superior to all claims, debts, or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You or Your representative, Your estate, Your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help You to pursue Your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be benefits advanced.
- If You receive any payment from any party because of sickness or injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative shall hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.
- By participating in and accepting benefits from the Plan, You agree that (i) any amounts recovered by You from any third party shall constitute Plan assets to the extent of the amount of Plan benefits provided on behalf of the Covered Person, (ii) You and Your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) You shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to Your own negligence.
- By participating in and accepting benefits from the Plan, You agree to assign to the Plan any benefits, claims or rights of recovery You have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the benefits the Plan has paid for the sickness or injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, You acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not You choose to pursue the claim, and You agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative
  or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits You receive for the sickness or injury out of any settlement, judgment or other recovery from any third party

considered responsible and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs a sickness or injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused You to suffer a sickness or injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.
- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You or Your dependents, deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

RIGHT OF RECOVERY

The Plan also has the right to recover benefits it has paid on You or Your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the Calendar Year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the Calendar Year.

Benefits paid because You or Your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a benefit for You or Your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, and/or

- reduce a future benefit payment for You or Your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to You or Your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the Calendar Year, the Plan will send You or Your Dependent a monthly statement identifying the amount You owe with payment instructions. The Plan has the right to recover benefits it has advanced by:

- submitting a reminder letter to You or a covered Dependent that details any outstanding balance owed to the Plan; and/or
- conducting courtesy calls to You or a covered Dependent to discuss any outstanding balance owed to the Plan.

Clerical errors, such as inaccurate effective or termination dates, or erroneous mailings, will not change the rights or obligations of any Covered Person.

PHYSICAL EXAMINATIONS

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

ASSIGNMENT OF BENEFITS PAYMENTS

Benefit payments are automatically assigned to the Provider of services when the Provider is in the UnitedHealthcare Network. In all other circumstances, You will need to assign benefits directly with the Provider in order for payments to be made directly to the Provider of services. Direct payment to a Provider is only a convenience and not a benefit under the Plan and does not make the Provider into a beneficiary or assignee or otherwise confer on the Provider any rights under the Plan or ERISA. You may not assign the right under Section 502(a) of ERISA to file suit (including for breach of fiduciary duty) or otherwise confer on the Provider any rights under the Plan or ERISA.

When You assign Your benefits under the Plan to a Non-Network Provider with UnitedHealthcare's consent, and the Non-Network Provider submits a claim for payment, You and the Non-Network Provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of benefits under the Plan, the assignment must reflect the Covered Person's agreement that the Non-Network Provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that Your benefit payment should be made directly to the Provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the Provider for Your convenience, but will treat You, rather than the Provider, as the beneficiary of Your claim. If benefits are assigned or payment to a Non-Network Provider is made, ACME reserves the right to offset benefits to be paid to the Provider by any amounts that the Provider owes ACME (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan) pursuant to the Refund of Overpayments section.

UnitedHealthcare will pay benefits to You unless:

- The Provider submits a claim form to UnitedHealthcare that You have provided signed authorization to assign benefits directly to that Provider.
- You make a written request for the Non-Network Provider to be paid directly at the time You submit Your claim.

UnitedHealthcare will only pay benefits to You or, with written authorization by You, Your Provider, and not to a third party, even if Your Provider purports to have assigned benefits to that third party.

Form of Payment of Benefits

Payment of benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where benefits are payable directly to a Provider, such adequate consideration includes the forgiveness in whole or in part of amounts the Provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

REFUND OF OVERPAYMENTS

If the Plan pays benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- All or some of the expenses were not paid by You or did not legally have to be paid You; or
- All or some of the payment the Plan made exceeded the benefits under the Plan; or All or some of the payment was made in error.

The refund equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Plan may reduce the amount of any future benefits for the Covered Person that are Covered Health Services. The reductions will equal the amount of the required refund. If the refund is due from another person or organization, You will agree to help the Plan get the refund when requested.

Incentives to Provider

Network Providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect Your access to health care.

Examples of financial incentives for Network Providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network Providers receives a monthly payment from
  UnitedHealthcare for each Covered Person who selects a Network Provider within the group to perform or coordinate certain health services. The Network Providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- Bundled payments –certain Network Providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. Your Copayment and/or Coinsurance will be calculated based on the Provider type that received the bundled payment. The Network Providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If You receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Copayment and/or Coinsurance

UnitedHealthcare uses various payment methods to pay specific Network Providers. From time to time, the payment method may change. If You have questions about whether Your Network Provider's contract with UnitedHealthcare includes any financial incentives, UnitedHealthcare encourages You to discuss those questions with Your Provider. You may also call UnitedHealthcare at the telephone number on Your ID card. UnitedHealthcare can advise whether Your Network Provider is paid by any financial incentive, including those listed above.

Relationship with Providers
UnitedHealthcare has agreements in place that govern the relationships between it and ACME America, Inc. and Network Providers, some of which are affiliated providers. Network Providers enter into agreements with UnitedHealthcare to provide Covered Health Services to Covered Persons.

ACME America, Inc. and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, ACME America, Inc. and UnitedHealthcare arrange for health care providers to participate in a Network and administer payment of benefits. Network Providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not ACME America, Inc.'s employees nor are they employees of UnitedHealthcare. ACME America, Inc. and UnitedHealthcare are not responsible for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

ACME America, Inc. is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in Your enrollment or the termination of Your coverage).
- The timely payment of the service fee to UnitedHealthcare.
- The funding of benefits on a timely basis.
- Notifying You of the termination or modifications to the Plan.

When Health Care Coverage Ends

Your coverage under the medical, dental and vision plans will end on the earliest of the following:

- The last day of the period in which You fail to make any required contribution,
- The last day of Your employment with ACME,
- The date a plan is discontinued, or
- The date You no longer meet the eligibility requirements.

Your covered Dependents' coverage will end on the earliest of the following:

- The last day of the period in which You fail to make any required contributions,
- The date Your coverage ends,
- The date a plan is discontinued,
- The date You and Your Spouse divorce or legally separate,
- The date Your Qualified Domestic Partnership ends,
- The date Your Dependent becomes covered under this Plan as an Employee (except with respect to life insurance), or
- The date Your Dependent Child(ren) no longer meets the Plan's eligibility requirements (e.g., the last day of the month in which he or she turns 26, provided that such Child is not permanently and totally disabled).

Note: If You or Your Dependent(s) lose Plan coverage eligibility, coverage will end the date the eligibility was lost.

ACME will make any required payroll deductions associated with Your benefit elections from Your final paycheck. Cost and credits are not pro-rated based on the number of days You are covered in a pay period.

Rehired Employees

Employees who end employment with ACME and rehired are subject to the following enrollment rules:

- If You are rehired within 30 days, the elections in force on Your last day of prior employment will be reinstated for the remainder of the Plan Year.
- If You are rehired after 30 days, You will be required to make new benefit elections for the remainder of the Plan Year within the required enrollment period.

Employees Returning from a Leave

Employees who lost healthcare coverage during their leave, then return to work, are subject to the following benefit reinstatement rules:

- If You lost health coverage during a leave of absence and return to work (working 20 or more hours per week) within the same calendar year that Your health coverage ended, and before November 15th, Your most recent benefit elections will be reinstated. If You were enrolled in a Flexible Spending Account (FSA) and/or Health Savings Account (HSA) You will need to contact ACME US Benefits to request to have Your per pay-check contribution amount recalculated to meet Your elected goal amount. If You retrun to work after November 15th, Your FSA and/or your HSA will not be reinstated for the remainder of the calendar year.
- If You lost health coverage during your leave of absence and return to work (working 20 or more hours per week) in a different calendar year than when Your health coverage ended, You will need to re-elect your benefits within 31 days from Your Return to work. If You fail to re-elect Your benefits within Your enrollment window, You will automatically be enrolled into ACME's default coverage.

For information on when coverage ends for Life, Accidental Death and Dismemberment, and Long Term Disability, please consult the specific Certificate of Coverage.

COVERAGE IN THE EVENT OF AN EMPLOYEE DEATH

In the event of an Employee death, medical, dental, and vision coverage for currently covered Dependents will continue through COBRA. The COBRA continuation period will be subsidized for six months from the date of death.

Disability Extensions Under UnitedHealthcare & HPHC Passport Plans

If you are enrolled in a UnitedHealthcare medical plan and are totally disabled when your employment and/or coverage ends, UnitedHealthcare will not extend your medical beneifts for the disabiling condition beyond that which is required by Federal Law. Review the When Coverage Ends section for more information about extending your medical benefits.

Refer to "When Coverage Ends"

Disability Extensions Under HMO Medical Plans

Kaiser Permanente (California) — If You are enrolled in Kaiser Permanente and are totally disabled when Your employment and/or coverage ends, Kaiser Permanente will extend Your medical benefits for the disabling condition for up to 12 months or until You are no longer disabled or are covered under another group health plan, whichever is earlier. To be eligible for this extension, Kaiser Permanente must continue to receive any applicable monthly or supplemental payments.

Kaiser Permanente (Colorado, Georgia, Mid-Atlantic, Oregon and Washington) – If You are enrolled in a Kaiser Permanente Plan outside of California and are totally disabled when Your employment and/or coverage ends, Kaiser Permanente will not extend Your medical benefits for the disabling condition.

Please contact the HMO directly if You need additional information on the extension of benefits provisions available under the Plan. This document only provides a brief description of HMO benefits and is not the legal document regulating the HMO Plan.

These extensions are extensions for the disabling condition only. You also may have rights to COBRA continuation or conversion. Review the When Healthcare Coverage Ends section for more information about extending Your medical benefits.

Provisions For Employees Who Are Residents Of Hawaii

The Hawaii Prepaid Health Care Act (Act) requires certain Employees who reside in Hawaii to be covered by the health care Plans and programs provided under the Plan at times during which the medical Plans might not otherwise provide coverage. The following rules will apply and shall override any inconsistent rules set forth in the Plan, but only to the extent required by the Act. Provisions of the
Act shall not override any provisions of the Plan that are more generous or provide greater benefits than those provided under the Act.

a. **Employees:** Employees classified as Part-Time Employees will be treated as Employees for all purposes under the health care plans provided under the Plan.

b. **Mandatory:** Employees must enroll in a health care plan to which ACME contributes, unless they are entitled to an exemption pursuant to the Act.

c. **Exemption Procedure:** Employees who are entitled to an exemption from the coverage requirement in Subsection above and who elect not to be covered must file Form HC-5 (supplied by the Hawaii Department of Labor and Industrial Relations) with the appropriate payroll office within 31 days after the date of their employment or the date when they become exempt.

Commencement Of Coverage

a. **Regular Employees:** Coverage for Employees (if they have not claimed an exemption on Form HC-5) will become effective on the first day of the calendar month coinciding with or next following a continuous four-week period of employment with ACME, working not less than 20 hours during each of the four weeks.

b. **Other Employees:** Coverage for Part-Time, seasonal, or temporary Employees (if they have not claimed an exemption on Form HC-5) will become effective on the first day of the calendar month coinciding with or next following the date when they become Employees pursuant to Subsection (a) above.

c. **Exemption Expires**: An Employee who filed Form HC-5 and who is no longer entitled to the exemption from the coverage requirement above must promptly notify the appropriate payroll office by filing a new Form HC-5. Such an Employee must enroll in a health care Plan to which ACME contributes. Coverage will become effective on the first day of the calendar month coinciding with or next following the date of the notification; provided such Employee has completed a continuous four-week period of employment with ACME, working not less than 20 hours during each of the four weeks.

d. **Dependents:** Coverage for “Eligible Dependents” will become effective on the date when the Employee’s coverage becomes effective, if the required application for coverage for all “Eligible Dependents” is properly filed with ACME within 31 days after the Employee becomes an Employee. Dependents who become non-Hawaii residents due to a Qualified Family Status Change – such as college, Qualified Medical Child Support Order (“QMCSO”) – may remain on the Hawaii Health Care Plan.

e. **Options:** An individual to whom the provisions of this section apply must elect the Hawaii Health Care Plan to which ACME contributes within 31-days after becoming an Employee.

f. **Termination of Coverage:** If a covered Employee is prevented from working his or her normal job because of sickness or disability, the Employee’s coverage will continue for either:

- 90-days following the month in which the Employee becomes disabled, or

- the period for which ACME has undertaken the payment of the Employee's regular wages, whichever is longer

g. **Electing to Terminate Coverage:** An Employee who commences coverage will not be permitted to terminate coverage unless the Employee provides satisfactory proof that the Employee is either exempt from the Act's coverage requirements or has other coverage meeting the Act's requirements.

COBRA Continuation Coverage Rights

GENERAL

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available when You would otherwise lose Your group health coverage under the Plan. It can also become available to Your Spouse and dependent Children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan.

Continuation of Coverage Options

If You become entitled to elect COBRA continuation coverage when You otherwise would lose group health coverage under a group health plan, You should consider all options You may have to get other health coverage before You make Your decision.

One coverage option is the new health insurance marketplace (Marketplace). The Marketplace offers health insurance that includes comprehensive coverage, from doctors and medications to hospital visits. Qualified health plans in the Marketplace present their price and benefit information in simple terms so that You can make apples-to-apples comparisons. For more information, visit www.healthcare.gov.

Another option may be "special enrollment" into other group health coverage. Under the Health Insurance Portability and Accountability Act (HIPAA), if You or Your dependents are losing eligibility for group health coverage, including eligibility for continuation coverage, You may have a right to enroll in other group health coverage without waiting until the next open enrollment (special enrollment). For example, special enrollment allows an Employee losing eligibility for group health coverage to enroll in a Spouse's plan. Another example of special enrollment is a dependent losing eligibility for group health coverage and may enroll in a different parent's group health plan. To be eligible for the special enrollment opportunity, You or Your dependent must have had other health coverage when You previously declined coverage in the plan in which You now want to enroll. To be eligible for special enrollment, You or Your dependent must request it within 30 days of the loss of other coverage.

If You or Your dependents choose to elect COBRA continuation coverage instead of special enrollment, You may not have another opportunity to request special enrollment in a Marketplace plan until You have exhausted Your continuation coverage. In order to exhaust COBRA continuation coverage, You or Your dependent must receive the maximum period of continuation coverage available without early termination. You must request special enrollment within 30 days of the loss of continuation coverage.

Finally, individuals in a family may be eligible for health insurance coverage through the Children's Health Insurance Program (CHIP). For more information, visit insurekidsnow.gov or call 1.877.KIDS.NOW (1.877.543.7669).

What Is COBRA Continuation Coverage?

COBRA 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 section. After a qualifying event occurs and any required notice of that event is properly provided to ACME, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, Your Spouse or Qualified Domestic Partner, and Your dependent Children could become qualified beneficiaries and would be entitled to elect COBRA coverage if coverage under the

Plan is lost because of the qualifying event. (Certain newborns, newly adopted Children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.) Under the Plan, qualified beneficiaries who elect COBRA coverage must pay for that coverage.

Who Is Entitled to Elect COBRA?

If You are an Employee, You will be entitled to elect COBRA coverage if You lose Your group health 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 or Qualified Domestic Partner of an Employee, You will be entitled to elect COBRA coverage if You lose Your group health coverage under the Plan because any of the following qualifying events happens:

- Your Spouse or Qualified Domestic Partner dies;
- Your Spouse's or Qualified Domestic Partner's hours of employment are reduced;
- Your Spouse's or Qualified Domestic Partner's employment ends for any reason other than his or her gross misconduct; You become divorced or legally separated from Your Spouse; or You dissolve your Qualifiied Domestic Partnership.
- Also, if Your Spouse (the Employee) reduces or eliminates Your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for You even though Your coverage was reduced or eliminated before the divorce or legal separation.

A person enrolled as the Employee's dependent Child will be entitled to elect COBRA coverage if he or she loses group health 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 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 coverage to qualified beneficiaries only after ACME has been timely notified that a qualifying event has occurred. For some qualifying events, the Plan will offer COBRA coverage to qualified beneficiaries only after ACME's COBRA Administrator is notified by ACME of the following events:

- the end of employment;
- the reduction of hours of employment; or the death of the Employee.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Employee and Spouse, dissolution of domestic partnership between Employee and Qualified Domestic Partner or a dependent Child's losing eligibility for coverage as a dependent Child) causing a loss of coverage, a COBRA election will be available to You only if You notify ACME by using one of the methods below.

- Access the ACME US Benefits Enrollment System to submit Your change online
- Contact ACME US Benefits at benefits_us@ACME.com
- Contact ACME's COBRA Administrator (BenefitConnect | COBRA) at the phone number below Submit a written notice

You must submit Your change within 60 days after the date of the qualifying event. In providing this notice, You must follow the notice procedures specified in the How, When and Where to Send Notices section. If these

procedures are not followed, or if the notice is not provided to ACME during the 60-day notice period, ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA COVERAGE. If You need help acting on behalf of an incapacitated beneficiary, please contact BenefitConnect | COBRA (ACME's COBRA Administrator) for assistance.

ACME's COBRA Administrator
BenefitConnect | COBRA
DEPT: COBRA
PO Box 981915
El Paso, TX 79998
1-877-29-COBRA (1-877-292-6272) (858-314-5108 International only)

ELECTING COBRA

Each qualified beneficiary will have an independent right to elect COBRA coverage. Covered Employees, Spouses, and Qualified Domestic Partners (if the Spouse or Qualified Domestic Partner is a qualified beneficiary) may elect COBRA coverage on behalf of all of the qualified beneficiaries, and parents may elect COBRA coverage on behalf of their Children.

Any qualified beneficiary for whom COBRA coverage is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE. You will not have to show that You are insurable to choose continuation coverage. However, You will have to pay the COBRA premium rate for Your coverage plus a 2% administration fee. Note: The COBRA premiums are not the same prices You paid while enrolled with ACME. ACME highly subsidizes premium costs for covered Employees and family members. The COBRA premiums are not subsidized and include a 2% administration fee.

HOW LONG DOES COBRA LAST?

COBRA coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the covered Employee's divorce or legal separation, dissolution of domestic partnership of covered Employee, or a dependent Child losing eligibility as a dependent Child, COBRA coverage under the Plan's group health components can last 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, COBRA coverage under the Plan generally can last for up to a total of 18 months. COBRA coverage under the Health FSA component can last only until the end of the Plan year in which the qualifying event occurred—see the paragraph below entitled "Health FSAs and COBRA." The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage periods as follows:

- the date You fail to timely pay the monthly premium;
- the date ACME ceases to provide any group health benefits to employees and/or their dependents;
- the date You and/or Your covered dependents become covered under another group health plan; or
- the date You and/or Your covered dependents begin receiving coverage through Medicare.

There are three ways (described in the following paragraphs) in which the period of COBRA coverage resulting from a termination of employment or reduction of hours can be extended. (The period of COBRA coverage under the Health FSA cannot be extended under any circumstances.)

Disability extension of COBRA coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled and You notify ACME's COBRA Administrator in a timely fashion, all of the qualified beneficiaries in Your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered

Employee's termination of employment or reduction of hours. The qualified beneficiary must be disabled at any time within 60 days after the covered Employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). The disability extension is available only if You notify ACME's COBRA Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- The date of the Social Security Administration's disability determination; or
- The date of the covered Employee's termination of employment or reduction of hours; or
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan due to the covered Employee's reduction of hours (e.g., medical leave of absence).

You must also provide a copy of the Social Security Determination of Disability notice within 18 months after the covered Employee's termination of employment or reduction of hours in order to be entitled to a disability extension. If these procedures are not followed, during the 60-day notice period and within 18 months after the covered Employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.

You will be required to pay up to 150% of the COBRA premium during the 11-month extension.

Second qualifying event extension of COBRA coverage

If Your family experiences another qualifying event while receiving COBRA coverage because of the covered Employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the Spouse, Qualified Domestic Partner, and dependent Children receiving COBRA coverage can get up to 7 or 18 additional months of COBRA coverage. The maximum coverage length is 36 months, provided notice of the second qualifying event is properly given to the Plan.

The extension applies if the Employee or former Employee:

- dies;
- gets divorced or legally separated or dissolves domestic partnership; or
- the dependent Child stops being eligible under the Plan as a dependent Child.

This extension is not available under the Plan when a covered Employee becomes entitled to Medicare after his or her termination of employment or reduction of hours because the Medicare entitlement would not have caused a loss of coverage under the Plan if it had been the first qualifying event.

This extension due to a second qualifying event is available only if You notify ACME's COBRA Administrator in writing of the second qualifying event within 60 days after the date of the second qualifying event. If these procedures are not followed, or if the notice is not provided to ACME's COBRA Administrator during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.

Medicare Extension for Spouse, Qualified Domestic Partner and Dependent Children

When the qualifying event is a termination 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 coverage for qualified beneficiaries (other than the Employee) who lose coverage as a result of the qualifying event can last until up to 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 employment terminates, COBRA coverage for his Spouse, Qualified Domestic Partner and Children who lost coverage as a result of his termination 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). This COBRA coverage period is available only if the covered Employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Health Care Flexible Spending Accounts (FSA) and COBRA

COBRA coverage under the Health Care Flexible Spending Accounts (FSAs) will be offered only to qualified beneficiaries losing coverage who have "under spent" the amount contributed to the Health Care FSAs. A qualified beneficiary has an "under spent" account if the annual limit elected by the covered Employee plus any carryover from the prior Plan Year, reduced by reimbursements up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health Care FSA COBRA coverage that will be charged for the remainder of the Plan Year. COBRA coverage will consist of the Health Care FSA 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 does not apply to Health Care FSAs. ACME allows participants to carry over up to $610 for 2023 and $640 for 2024 of Your unspent Health Care FSA contributions to the next Calendar Year so long as You are enrolled in the Health Care FSA COBRA coverage at the end of the Calendar Year. However, additional FSA contributions may not be made and reimbursement of any qualified expense(s) is limited to the applicable COBRA period. The carryover provision does NOT apply to the Dependent Care Account.

Unless otherwise elected, all qualified beneficiaries who were covered under the Health Care FSA will be covered together for Health Care FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health Care FSA annual limit and a separate premium. If You are interested in this alternative, contact ACME's COBRA Administrator for more information.

More Information about Individuals Who May Be COBRA Qualified Beneficiaries

- Children born to or placed for adoption with the covered Employee during COBRA coverage period
- A Child born to, adopted by, or placed for adoption with a covered Employee during a period of COBRA coverage is considered a qualified beneficiary if, the covered Employee is a qualified beneficiary, and the covered Employee has elected COBRA coverage for himself or herself. The Child's COBRA coverage begins when the Child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the Employee. To be enrolled in the Plan, the Child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).
- Alternate recipients under QMCSOs
- A Child of the covered Employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received during the covered Employee's period of employment with ACME is entitled to the same rights to elect COBRA coverage as an eligible dependent Child of the covered Employee, regardless of whether that Child would otherwise be considered a dependent.

If You Have Questions

Questions concerning Your Plan or Your COBRA rights should be addressed to the contact or contacts identified below. For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect Your family's rights, You should keep ACME and/or ACME's COBRA Administrator informed of any changes in the addresses for Yourself and family members. You should also keep a copy, for Your records, of any notices You send.

NOTICES MUST BE RECEIVED TIMELY

WARNING : If Your notice is late or if You do not follow these notice procedures, You and all related qualified beneficiaries will lose the right to elect COBRA coverage (or will lose the right to an extension of COBRA coverage, as applicable).

How, When, and Where to Send Notices
You may provide notice online, by calling the number below, or mailing Your notice to:

COBRA ADMINISTRATOR
BenefitConnect COBRA
PO Box 981915
El Paso, TX 79998
1-877-29-COBRA (1-877-292-6272)
(858-314-5108 International only)

ACME US BENEFITS
ACME America, Inc.
500 ACME Parkway
Redwood Shores, CA 94065

(650) 558-4100 or (800) 287-6720

Benefits_us@ACME.com

If mailed, Your notice must be postmarked no later than the last day of the applicable notice period. (The applicable notice periods are described in the paragraphs above entitled "You Must Give Notice of Some Qualifying Events," "Disability extension of COBRA coverage," and "Second qualifying event extension of COBRA coverage.")

Information Required for All Notices
Any written notice You provide must include:

- the name of the Plan (ACME America, Inc. Flexible Benefit Plan);
- the name and address of the Employee who is (or was) covered under the Plan;
- the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event;
- the qualifying event and the date it happened; and
- the certification, signature, name, address, and telephone number of the person providing the notice.

Additional Information Required for Notice of Qualifying Event:
If the qualifying event is a divorce or legal separation, Your notice must include in writing the information listed in the above section "Information Required for All Notices." In addition, You must also include the date of Your divorce or legal separation as stated on the court filed decree of divorce or legal separation. If Your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if You are notifying ACME that Your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, Your notice must include evidence satisfactory to ACME that Your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Additional Information Required for Notice of Disability:

- Any notice of disability that You provide must also include:
- the name and address of the disabled qualified beneficiary;
- the date that the qualified beneficiary became disabled;
- the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage;
- the date that the Social Security Administration made its determination;
- a copy of the Social Security Administration's determination; and
- a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

Additional Information Required for Notice of Second Qualifying Event: Any notice of a second qualifying event must also include:

- The names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; and

- the second qualifying event type (e.g., divorce) and the date that it happened; and
- if the second qualifying event is a divorce or legal separation, You may be required to submit a copy of the decree of divorce or legal separation

Who May Provide Notice of Qualifying Events?
The covered Employee (i.e., the Employee or former Employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

ADDITIONAL COBRA RIGHTS FOR TRADE-DISPLACED EMPLOYEES

The Trade Act of 2002 gives certain workers who lose their jobs because of import competition or a transfer of production to other countries, the right to a second opportunity to elect COBRA continuation coverage, and the right to take a federal tax credit for their medical plan premiums, called a Health Coverage Tax Credit (HCTC). The federal Department of Labor and the various state agencies help identify individuals who may be eligible for the second COBRA election period and the Health Coverage Tax Credit. An individual may be eligible for these rights if he or she is, as defined by the Trade Act:

- An eligible Trade Adjustment Assistance recipient;
- An eligible Alternative Trade Adjustment Assistance recipient;
- An eligible Pension Benefit Guaranty Corporation (PBGC) pension recipient who is at least 55 years old.

If You become eligible to receive Trade Adjustment Assistance or Alternative Trade Adjustment Assistance within six months of losing group health Plan coverage, You may be entitled to a second COBRA election period with respect to group health plan coverage only.

To obtain this second COBRA election period, You must provide a copy of the certificate issued to You by Your state workforce agency entitling You to federal trade adjustment assistance to ACME. ACME will provide You with a COBRA continuation coverage election notice. Your COBRA continuation coverage election must be made during the 60-day period that begins on the first day You become eligible for the federal assistance referenced above, but no later than six months after You lost ACME group health Plan coverage. If You elect COBRA continuation coverage during this period, COBRA continuation coverage will commence on the first day of the second election period. Your COBRA continuation coverage period, however, will be measured from the date You initially lost ACME group health Plan coverage. The second election period does not extend the COBRA continuation coverage period available to You.

The Trade Act also provides recipients of Trade Adjustment Assistance and Alternative Trade Adjustment Assistance and PBGC pension recipients age 55 or older with a federal tax credit of up to 72.5 percent of the premiums paid for qualified medical insurance, including COBRA continuation coverage. The credit may be claimed on an eligible individual's year-end federal tax return or in advance by participating in the advance payment program of the Health Coverage Tax Credit (HCTC) program. The HCTC program is administered by the federal government.

If You have questions about the second COBRA election period or the HCTC, You should call the HCTC Customer Contact Center at the number that appears below. You may also obtain information about the Trade Act at the IRS website, or at http://www.irs.gov/individuals/article/0,,id=109915,00.html.

HCTC Customer Contact Center
Toll free at 1-8660-628-4282
TDD/TTY toll free at 1-866-626-4282
Hours of operation: 7:00 AM to 7:00 PM Central time, Monday through Friday

COST OF COBRA COVERAGE

You will be responsible for the total cost of medical, dental, vision, and/or Health Care Flexible Spending Account coverage. The amount and method of payment are shown on the COBRA election form and are subject to change. You may also view COBRA costs at www.ACMEbenefits.com. The COBRA Administrator will notify You if Your costs will change.

Your first payment must be made to the COBRA Administrator no later than 45 days from the date of Your election. This payment must cover the cost of COBRA coverage from the qualifying event up through the end of the month before the month in which You make Your first payment. **If You do not make Your first payment for COBRA coverage in full within 45 days after the date of Your election, You will lose all COBRA rights.**

Thereafter, Your payment is due on the first of each month, but no later than the end of the month. You will not be considered to have made any payment if Your check is returned due to insufficient funds. **If payment is not postmarked by the end of the month, COBRA coverage will end.**

You will not receive monthly billing statements, and it is Your responsibility to remit premiums by the required due date.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

If You are on a military leave without pay, You are eligible to continue ACME's health plan coverage in accordance with the
Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Periods of continuation coverage under USERRA will run concurrently with periods of COBRA continuation coverage. You are covered under USERRA if You serve voluntarily or involuntarily as a member of the uniformed services, including serving in the reserves or as designated by the
President. The uniformed services include the U.S. Army, Navy, Marines, Air Force, Coast Guard, and National Guard, and the public health commissioned corps.

You, Your Spouse or Your Dependent's period of continuation coverage under USERRA will begin on the date of the qualifying event of Your losing coverage under ACME's health plan due to commencement of a military leave without pay and shall end on the earliest of the following dates:

- The 24-month period beginning on the date on which Your military leave without pay begins;
- The period ending on the day after the date on which You fail to timely apply for or return to a position of employment with ACME, as determined under section 4312(e) of USERRA.

You should note that most of the obligations under USERRA are the same as COBRA, but USERRA continuation will not end because You become entitled to another health plan or Medicare and You have no second qualifying events under USERRA.

Conversion To Individual Medical Coverage

UNITEDHEALTHCARE: HSA MEDICAL PLAN, PPO, EPO , OR OUT-OF-AREA PLANS

There is no conversion option available to You and/or Your Dependents when active or COBRA coverage ends.

KAISER PERMANENTE HMO

If You are covered by Kaiser Permanente and Your coverage ends, You and/or Your Dependents may convert the group coverage into an individual Kaiser Permanente plan membership.

You or Your Dependent must apply for an individual plan membership within 31 days after the group medical coverage ends, or whenever COBRA continuation coverage ends. The availability of extended benefits for a totally disabled individual does not waive this 31-day filing date.

The cost, forms, and terms of the available individual plan memberships are based on Kaiser Permanente's rules for conversion at the time You (or one of Your Dependents) apply. For more information, You may contact Kaiser Permanente.

Legal and Administrative Information

This section of the Plan document and Summary Plan Description provides You with important information about the ACME America, Inc. Flexible Benefit Plan, including the rights guaranteed You under federal law, and additional administrative information required by law. The Plan consists of this document, the Family Status Changes Qualified Events document, and all HMO Evidences of Coverage and all life, AD&D and Long Term Disability insurance policies, certifications of insurance, and/or summary booklets, which are incorporated herein by reference. Plan participants and beneficiaries should not rely on any oral description of the Plan because the written terms of the Plan will always govern. For information and assistance on benefit matters, we encourage You to contact ACME US Benefits at Benefits_us@ACME.com or call 650-506-9800.

NAME AND ADDRESS OF EMPLOYER

ACME America, Inc.
500 ACME Parkway
Redwood City, CA 94065

ADMINISTRATIVE INFORMATION

Plan Sponsor & Plan Administrator: ACME America, Inc.
500 ACME Parkway
Redwood City, CA 94065
650-506-9800

Plan Name: ACME America, Inc. Flexible Benefit Plan (the "Plan")
ACME America, Inc. EIN: 94-2805249 **Plan Number:** 501

AGENT FOR SERVICE OF LEGAL PROCESS

Process may be served on the Plan by directing such legal process to the Plan Administrator or to ACME's registered agent for service of legal process:

Corporation Service Company (CSC)
2711 Centerville Road, Suite 400
Wilmington, DE 19808 888-
690-2882
sop@cscglobal.com

Plan Year
The Plan is administered on a Calendar Year basis, beginning on January 1 and ending on December 31.

Type of Administration
The Plan is administered in accordance with administrative services contracts or insurance policies.

Funding Of The Plans/Source Of Contributions
Medical, dental and vision benefits are paid from ACME's general assets on a self-insurance basis, including benefits that are paid from a claims administrator's account in order to facilitate administration of the benefit program. UnitedHealthcare's function is to provide administrative and fiduciary services. MetLife and Vision Service Plan (VSP) provide administrative services.

The HMO Plans (Kaiser Permanente) are funded on an insured basis. Additionally, the Employee Assistance Program (EAP), life insurance, Accidental Death and Dismemberment, and Long Term Disability insurance are all funded on an insured basis.
The source of contributions for the Plan includes ACME's contributions and Employee contributions (on both a pre-tax and after-tax basis pursuant to salary reductions), as determined by the Plan Administrator. There is no separate fund or account that secures the benefits under the Plan.

Governing Law
The Plan shall be construed, administered, and enforced according to the laws of the State of California, to the extent not superseded by the Code, ERISA, or any other federal law.

Assignment of Benefits
To the extent permitted by law and except as provided in Assignment of Benefit Payments, the rights or interests of any Covered Person to any benefits under the Plan shall not be subject to attachment or garnishment or other legal process by any creditor of any such Covered Person, nor shall any such Covered Person have any right to assign any of the benefits which the Covered Person may expect to receive under this Plan, and any attempt to assign any right to benefits under the Plan shall be void.

Guarantee of Tax Consequences
ACME makes no commitment or guarantee that any amount paid to or for the benefit of a Covered Person under the Plan will be excludable from gross income for federal, state, or local income tax purposes. It is the obligation of each Employee to determine whether each payment under the Plan is excludable from the Employee's gross income for federal, state, and local income tax purposes and to notify ACME if the Employee has any reason to believe that such payment is not so excludable.

Severability
Should any part of this Plan be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

Contribution Methodology
Refer to "Employee Cost to Participate"

Discretionary Authority Of Plan Administrator And Plan Fiduciaries
In carrying out their responsibilities, ACME as the Plan Administrator, and the Plan fiduciaries have full discretionary authority to adopt rules and procedures to implement the Plan, make factual determinations, interpret the terms of the Plan, to decide any questions in connection with the administration of the Plan, including to determine eligibility for benefits under the Plan and to determine the amount of such benefits. The Plan Administrator generally supervises the operation of the Plan and may delegate any or all of this authority to a claims administrator. To the extent that authority is delegated, UnitedHealthcare and its affiliates (including, but not limited to, United Behavioral Health Naviguardand Optum), has all of the power and authority of the Plan Administrator. Any interpretation or determination made by such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation was arbitrary or capricious. The abuse of discretion standard applies to any claim for breach of fiduciary duty.

ACME has delegated to UnitedHealthcare and its affiliates (including, but not limited to, United Behavioral Health, Naviguard and Optum), MetLife, and Vision Service Plan (VSP) the discretion and authority to determine on ACME's behalf whether a treatment or supply is a Covered Health Service. UnitedHealthcare and its affiliates (including, but not limited to, United Behavioral Health Naviguard and Optum), MetLife and Vision Service Plan (VSP) is the named fiduciary that serves as the final review committee and, in its sole discretion, has the authority to interpret Plan provisions as well as facts and other information related to claims and appeals for the following benefits as applicable:

- UnitedHealthcare HSA Medical
- UnitedHealthcare Medium and Premium PPO
- UnitedHealthcare Exclusive Provider Organization (EPO)
- UnitedHealthcare Medium and Premium Out-of-Area
- UnitedHealthcare's Harvard Pilgrim Passport
- MetLife Dental (Plan I and Plan II)
- Vision Service (Plan I and Plan II)

ACME has designated Hartford Life and Accident Insurance Company ("Hartford") as the claims fiduciary for the long term disability benefits offered under the Plan. Hartford is granted full discretion and authority to determine eligibility for long term disability benefits and to construe and interpret all terms and provisions under the group insurance policy issued by Hartford.

ACME has designated Metropolitan Life Insurance Company ("MetLife") as the claims fiduciary for the group term life and AD&D benefits offered under the Plan. MetLife is granted full discretion and authority to determine eligibility for group term life and AD&D benefits and to construe and interpret all terms and provisions under the group insurance policy issued by MetLife.

Future of the Plan

ACME reserves the right to terminate, suspend, withdraw, amend, or modify the Plan in whole or in part at any time. Any such action is subject to applicable provisions of the Plan document. ACME reserves this right by action of its Executive Vice President, Human Resources. Termination of the Plan will not affect any claim incurred while the Plan was in force.

No Guarantee of Employment

The adoption and maintenance of the Plan by ACME is not a contract of employment between ACME and any Employee. Nothing contained in this Plan document/SPD gives any Employee the right to be retained in the employment of ACME or to interfere with ACME's right to discharge any Employee at any time for any reason. Similarly, the ACME benefit Plans do not give ACME the right to require any Employee to remain employed by ACME or interfere with the Employee's right to terminate employment with ACME at any time for any reason.

Your Benefits During Leave of Absence

For information about Your benefits during a leave of absence, please consult the Impact on Benefits During Leaves of Absence. The circumstances under which You may continue benefits and for how long are described therein.

Your Rights Under Federal Law

The Employee Retirement Income Security Act (ERISA) was enacted in 1974 to protect the interest of participants and beneficiaries in Employee benefit plans. As a participant in the Plan described in this Plan document and Summary Plan Description (SPD), You have certain rights and protections under ERISA, as outlined in the following statement adapted from regulations of the U.S. Department of Labor.

ERISA Rights Statement

As a participant in the Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Receive Information About Your Plan and Benefits
- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, 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 copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan 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 the summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for Yourself or Dependents if there is a loss of coverage under the Plan because 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 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 ACME 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 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 Plan 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 after You have exhausted all steps in the procedures for filing claims and appeals. 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 after all required reviews of Your claim have been completed. 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, United States 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, N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefit Security Administration.

Newborn and Mother's Health Protection Act
Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with Childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Provider (e.g., Your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or Out-of-Pocket costs so that any later portion of the 48hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce Your Outof-Pocket costs, You may be required to obtain notification or notify UnitedHealthcare. For information, contact UnitedHealthcare.

Women's Health and Cancer Rights Act (WHCRA)
For any participant or beneficiary of the Plan who currently is receiving Plan benefits for a mastectomy, the Plan will provide coverage for any necessary surgery and reconstruction of the breast on which a mastectomy was not performed in order to produce a symmetrical appearance.

This coverage will be subject to the same Deductibles and Copayments that apply to mastectomies under the Plan's current terms.
For information on coverage under the UnitedHealthcare Plans, see information provided elsewhere in this Plan document and Summary Plan Description (SPD) for details on the applicable Deductible and Copayment requirements for mastectomies. If You are enrolled in a Kaiser Permanente HMO plan, please consult the Evidence of Coverage provided by the specific plan.

Genetic Information Nondiscrimination Act (GINA)
Genetic information is Protected Health Information. In accordance with the Genetic Information Nondiscrimination Act, the Plan will not use or disclose genetic information for underwriting purposes, which include eligibility determinations, premium computations, applications of any pre-existing condition Exclusions, and any other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

HIPAA Notice of Privacy Practices

The ACME America, Inc. Flexible Benefit Plan ("Plan") is committed to protecting the privacy and security of the health information that You (or ACME) may submit to our service providers when participating in the Plan. This privacy policy describes how Your health information may be collected, used, disclosed, and protected by the Plan. Additionally, it describes how You can get access to this information. **PLEASE REVIEW IT CAREFULLY.**

NOTE: The Notice of Privacy Practices only applies to the healthcare benefits offered under the Plan. The notice does NOT apply to information that You may submit as part of the other non-healthcare components of the Plan, such as life insurance, accidental death & dismemberment (AD&D), long term disability, etc. Such information is covered and protected by ACME's Internal Privacy Policy.

Your Rights
You have certain rights and responsibilities and may: Receive a copy of Your health and health claims records

- Get a copy of Your paper or electronic medical record
- Correct Your health and health claims records
- Request confidential communication
- Ask us to limit the information we share
- Obtain a list of those with whom we've shared Your information
- Receive a printed copy of this privacy notice
- Choose someone to act for You
- File a complaint if You believe Your privacy rights have been violated

YOUR CHOICES

You have choices in the way that we use and share information as we:

- Answer coverage questions from Your family and friends
- Provide disaster relief
- Market our services and sell Your information

Our Uses and Disclosures
We may use and share Your information in certain transactions related to Plan operations, payment, and treatment as we:

- Help manage the health care treatment You receive
- Run our organization
- Pay for Your health services
- Administer the Plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests Respond to lawsuits and legal actions

Additional information
Additional information about Your Rights, Your Choices, Our Uses and Disclosures, Our Legal Obligations, and Contacts are located in the sections below.

YOUR RIGHTS	**When it comes to Your health information, You have certain rights.** This section explains Your rights and some of our responsibilities.

RECEIVE A COPY OF YOUR HEALTH AND CLAIMS RECORDS	You can ask to see or get an electronic or paper copy of Your medical record and other health information we have about You. Ask us how to do this.

- We will provide a copy or a summary of Your health information, usually within 30 days of Your request. We may charge a reasonable, cost-based fee.

ASK US TO CORRECT HEALTH AND CLAIMS RECORDS

- You can ask us to correct health information about You that You think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to Your request, but we'll tell You why in writing within 60 days.

REQUEST CONFIDENTIAL COMMUNICATIONS

- You can ask us to contact You in a specific way (for example, home or office hone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if You tell us You would be in danger if we do not.

ASK US TO LIMIT WHAT WE USE OR SHARE

- You can ask us NOT to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to Your request, and we may say "no" if it would affect Your care.

REQUEST A LIST OF THOSE WITH WHOM WE HAVE SHARED INFORMATION

- You can ask for a list (accounting) of the times we have shared Your health information for six years prior to the date You ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payments, and health care operations, and certain other disclosures (such as any You asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if You ask for another one with 12 months.

OBTAIN A COPY OF THIS PRIVACY NOTICE

- You can ask for a paper copy of this notice at any time, even if You have agreed to receive the notice electronically. We will provide You with a paper copy promptly.

CHOOSE SOMEONE TO ACT FOR YOU

- If You have given someone medical power of attorney or if someone is Your legal Guardian, that person can exercise Your rights and make choices about Your health information.
- We will make sure the person has this authority and can act for You before we take any action.

FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS ARE VIOLATED

- You can complain if You feel we have violated Your rights by contacting us using the information in the "Contacts" section below.
- If You believe that we have violated the terms of this Notice of Privacy Practices You can file a complaint with the **U.S. Department of Health and Human Services Office for Civil Rights** by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against You for fling a complaint.

YOUR CHOICES

For certain health information, You can tell us Your choices about what we share.

If You have a clear preference for how we share Your information in the situations described below, talk to us. Tell us what You want us to do, and we will follow Your instructions.

In these cases, You have both the right and choice to tell us to:

- Share information with Your family, close friends, or others involved in payment for Your care Share information in a disaster situation

NOTE: If You are not able to tell us Your preference, for example if You are unconscious, we may go ahead and share Your information if we believe it is in Your best interest. We may also share Your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share Your information unless You give us written permission:

- Marketing purposes
- Sale of Your information

OUR USES AND DISCLOSURES

How do we typically use or share Your health information?

We typically use or share Your health information in the following ways (see below):

HELP MANAGE THE HEALTH CARE TREATMENT YOU RECEIVE

 We can use Your health information and share it with professionals who are treating You.

EXAMPLE: A doctor sends us information about Your diagnosis and treatment plan so we can arrange additional services.

OPERATE THE PLAN

- We can use and disclose Your information to run the Plan and contact You when necessary.
- We are not allowed to use genetic information to decide whether we will give You coverage and the price of that coverage. This does not apply to long term care plans.

EXAMPLE: We use health information about You to develop better services for You.

PAY FOR YOUR HEALTH SERVICES

 We can use and disclose Your health information as we pay for Your health services.

EXAMPLE: We share information about You with Your dental plan to coordinate payment for Your dental work.

ADMINISTER YOUR PLAN

 We may disclose Your health information to certain employees of ACME for Plan administration.

EXAMPLE: We disclose health information about You to resolve a claim dispute.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share Your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share Your information for these purposes. For more information:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

HELP WITH PUBLIC HEALTH AND SAFETY ISSUES

- We can share health information about You for certain situations such as:

- Preventing disease
- Reporting adverse reactions to medications
- Preventing or reducing a serious threat to anyone's health or safety **DO RESEARCH**
- We can use or share Your information for health research. **COMPLY WITH THE LAW**
- We will share information about You if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

RESPOND TO ORGAN AND TISSUE DONATION REQUESTS AND WORK WITH A MEDICAL EXAMINER OR FUNERAL DIRECTOR We can share health information about You with organ procurement organizations.

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

ADDRESS WORKERS' COMPENSATION, LAW ENFORCEMENT, AND OTHER GOVERNMENT REQUESTS

We can use or share health information about You:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services **RESPOND TO LAWSUITS AND LEGAL ACTIONS**

We can share health information about You in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of Your protected health information.
- We will let You know promptly if a breach occurs that may have compromised the privacy or security of Your information. We must follow the duties and privacy practices described in this Notice of Privacy Practices and give You a copy of it at Your request.
- We will not use or share Your information other than as described here unless You tell us we can in writing. If You tell us we can, You may change Your mind at any time by letting us know in writing.

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about You. The new notice will be available upon request, on our web site, and we will mail a copy to You.

This Notice Is Effective On January 1, 2018

This Notice applies only to the healthcare components of the ACME America, Inc. Flexible Benefit Plan ("Plan"). It does not apply to the non-healthcare components of the Plan.

NOTE: ACME never markets or sells personal information.

CONTACT US

EMAIL Benefits_US@ACME.com
PHONE 650-506-9800
WEBSITE www.ACMEbenefits.com
MAILING ADDRESS ACME America, Inc.
500 ACME Parkway
Redwood Shores, Ca 94065

DIRECTORY OF PLANS AND ADMINISTRATORS

The following benefits are technically described by the U.S. Department of Labor as "welfare plans." The Plan carries Employer Identification Number 94-2805249, which is assigned to ACME America, Inc. by the Internal Revenue Service. All benefits listed are included in Plan #501 - ACME America, Inc. Flexible Benefit Plan.

Name and Type of Benefit	**Funding & Administrative Type**	**Name of Insurer Administrator of Services**	**Policy or Contract Number**	**Original Effective: Date and/or Amendment Date**
HSA Medical Plan Medium PPO Plan Premium PPO Plan EPO Plan EPO Plan (HI) Out-of-Area Plans Harvard Pilgrim Passport Plan (HPHC) Employee Assistance Program (EAP)	Self-Insured Third Party Administrator and Claims Fiduciary	**UnitedHealthcare (UHC) and its Affiliates (including, but not limited to, United Behavioral Health, and Optum)** 9900 Bren Road East Minnetonka, MN 55343 860-702-5000	228485	Effective: January 1, 2001 Amended: January 1, 2011 (Original Effective Date for Medical: February 1, 1983)
HMO Medical/Pharmacy Plan	Insured-Insurer	**Kaiser Permanente** P. O. Box 129232, Oakland, CA 94604-2923	CA – 26620; CO – 95669; Mid-Atl – 1464; NW – 14276; WA –	Effective: 01/01/1992; Amended: 01/01/2018
Dental Plans I & II	Self-Insured Third Party Administrator	**MetLife** 1 Madison Avenue New York, NY 10010 800-638-5433	300569	Effective: January 1, 2001 Amended: January 1, 2017 (Original Dental Effective: Date February 1, 1983)
Group Term Life Insurance & Accidental Death & Dismemberment (AD&D)	Insured - Insurer	**MetLife** 1 Madison Avenue New York, NY 10010 800-638-5433	91700	Effective January 1, 1996 Amended: January 1, 2017 (Original Life Insurance Effective: Date June 1, 1983)
Vision Plans I & II	Self-Insured Third Party Administrator	**Vision Service Plan (VSP)** 3333 Quality Drive Rancho Cordova, CA 95670 800-877-7195	12-134446	Effective: February 1, 1991 Amended: January 1, 2012 (Original Effective: Date for Vision February 1, 1991)
Health Care and Dependent Care Flexible Spending Accounts (FSA)	Self-Insured Third Party Administrator	**UnitedHealthcare (UHC)** 450 Columbus Boulevard Hartford, CT 06115-0450 860- 702-5000	228487	Effective: January 1, 2001 Amend: January 1, 2017
Second Medical Opinion	Third Party Administrator	**Included Health** 360 3rd St, San Francisco, CA 94107	N/A	Effective: March 1, 2018

Long Term Disability (LTD)	Insured – Insurer	**The Hartford** P.O. Box 2999 Hartford, CT 06104-2999 1-800-752-9713 (if about a claim) 1-800-523-2233 (if not about a claim)	GLT-395175	Effective: January 1, 2009 Amended: January 1, 2015

EXECUTION

IN WITNESS WHEREOF, ACME America, Inc. has caused this amendment and restatement of the ACME America, Inc. Flexible Benefit Plan and Summary Plan Description (SPD) to be executed on its behalf on this _____ day of December, 2023.

ACME America, Inc.

BY:

Joyce Westerdahl
Executive Vice President, Human Resources