copower™

Benefits made easy

UnitedHealthcare

Summary of Benefits

For plans effective April 1, 2019 through September 30, 2019

Part of the CoPower ***SELECT***™ portfolio of dental, vision and life plans underwritten by UnitedHealthcare and available through CoPower, Inc.

UnitedHealthcare®

CoPower and UnitedHealthcare

Get even more value with CoPower *SELECT*™

The addition of UnitedHealthcare to CoPower's portfolio equals a large selection of plans at very competitive price points. With two Dental Health Maintenance Organization (DHMO) plans, nine Dental Preferred Provider Organization (DPPO) plans, vision and life, this partnership provides more value to the CoPower *SELECT*™ portfolio.

Dental Overview

UnitedHealthcare's DHMO and PPO networks give you access to some of the largest dental networks in CA.[1] The plans are offered both as voluntary and employer sponsored (ER), giving you even more options. Plus, with UnitedHealthcare you have additional benefits, such as:

- Prenatal Dental Care Program
- Covered Oral Cancer Screening
- Consumer MaxMultiplier® (Available for PPO plans only see page 3 for details)

Voluntary Dental is available to any group and only requires 2 eligible employees and 2 enrolling to establish a PPO or DHMO policy.

Vision Overview

With three vision plans offered as both voluntary and employer sponsored, CoPower and UnitedHealthcare ensure there is a plan that fits your needs. With CoPower and UnitedHealthcare, you'll have access to:

- Discounted laser vision correction
- Discounts on contact lenses
- Preferred pricing on hearing aids

Vision participation requirements are only 2 eligible and 1 enrolling, no matter the group size.

Life Overview

Basic Life coverage provides a solid foundation of financial protection. Supplemental Life allows employees to purchase additional coverage that meets their unique needs. At no additional cost, you gain:

- Beneficiary services
- Travel assistance services
- Will and trust preparation services

[1] When compared to the largest competitors.

Dental PPO & DHMO Plans

For groups 2-100 eligible employees:

Dental Networks Information

- Among the largest PPO networks in CA with 39,000 access points, plus more than 402,000 access points nationwide to help cover employees across the U.S.[1]
- Among the largest DHMO networks in CA with over 2,300 unique locations[1]
- Average PPO discount is more than 30% in CA

Consumer MaxMultiplier® Program

If an employee or their dependent(s) visit their dentist for a regular checkup at least one time during the benefit year, they qualify to earn award dollars to use for future dental claims.[2] The number of award dollars is determined by the out-of-network maximum of the dental plan. Plus, award dollars can roll over year to year.

Dual Choice Options

Employer Sponsored Product Combinations

- Employer must contribute an amount equal to at least 50% of Employee Only premium for the lowest cost plan.
- Any DHMO can be combined with any PPO. At least 5 eligible, minimum of 5 enrolling with a minimum of one enrolling in each plan.
- Available PPO combinations: Classic 1000 PPO can be combined with Preferred 1500 or Elite 2000 PPO. At least 10 eligible, minimum of 8 enrolling with at least 5 enrolling in the High Plan.

Voluntary Product Combinations

- Allowed for groups with prior dental coverage.
- Any DHMO can be combied with any PPO. At least 5 eligible and a minimum of one enrolling in each plan.
- Available PPO combinations: Classic 1000 + Preferred 1500 OR Elite 2000. At least 10 eligible, minimum of 8 enrolling and at least 5 enrolling in the High Plan.

DENTAL COVERAGE 2-4	Classic 2-4 1000		Classic 2-4 1500	
	In-network	Out-of-network	In-network	Out-of-network
Plan Code	Voluntary: 1P650 ER Sponsored: 1P651		Voluntary: 1P652 ER Sponsored: 1P653	
Plan Type	Low		High	
Deductible	$50 Individual / $150 Family		$50 Individual / $150 Family	
Deductible Waived for Preventive Services	Yes		Yes	
Dental Provider Reimbursement Basis	MAC		MAC	
Calendar Year Max	$1,000		$1,500	
Diagnostic and Preventive Services	100%		100%	
Basic Services	80%		90%	80%
Major Services	50%		60%	50%
Endodontics, Periodontics, & Oral Surgery	Major Services		Major Services	
Orthodontics	Not Covered		Not Covered	

[1] When compared to the largest competitors.

[2] Members will not actually earn cash that they can access or withdraw. UnitedHealthcare adds the award dollars to the member's annual maximum for the following year and applies the dollars to qualifying claims.

Dental PPO Plans (continued)

DENTAL COVERAGE 5-100	Classic 1000	Classic 1000 with Ortho	Classic 1500	Classic 1500 with Ortho
	In/Out-of-Network	In/Out-of-Network	In/Out-of-Network	In/Out-of-Network
Plan Code	Voluntary: 1X654 ER Sponsored: 1X655	Voluntary: 1X685 ER Sponsored: 1X679	Voluntary: 1X656 ER Sponsored: 1X657	Voluntary: 1X686 ER Sponsored: 1X680
Plan Type	Low	Low	Mid	Mid
Deductible	$50 Individual / $150 Family		$50 Individual / $150 Family	
Deductible Waived for Preventive Services	Yes	Yes	Yes	Yes
Dental Provider Reimbursement Basis	MAC	MAC	MAC	MAC
Calendar Year Max	$1,000	$1,000	$1,500	$1,500
Diagnostic and Preventive Services	100%	100%	100%	100%
Basic Services	80%	80%	80%	80%
Major Services	50%	50%	50%	50%
Endodontics, Periodontics, & Oral Surgery	Basic Services	Basic Services	Basic Services	Basic Services
Orthodontics (Child only to age 19)	Not Covered	50% to max of $1,000	Not Covered	50% to max of $1,500

DENTAL COVERAGE	Preferred 1250	Preferred 1500 with Ortho	Elite 2000 with Ortho	
	In/Out-of-Network	In/Out-of-Network	In-Network	Out-of-Network
Plan Code	Voluntary: 1X658 ER Sponsored: 1X659	Voluntary: 1X660 ER Sponsored: 1X661	Voluntary: 1X662 ER Sponsored: 1X663	
Plan Type	High	High	High	
Deductible	$50 Individual / $150 Family		$50 Individual / $150 Family	
Deductible Waived for Preventive Services	Yes	Yes	Yes	
Dental Provider Reimbursement Basis	80th % - UCR	90th % - UCR	90th % - UCR	
Calendar Year Max	$1,250	$1,500	$2,000	$1,500
Diagnostic and Preventive Services	100%	100%	100%	
Basic Services	80%	80%	90%	80%
Major Services	50%	50%	60%	50%
Endodontics, Periodontics, & Oral Surgery	Basic Services	Basic Services	Basic Services	
Orthodontics (Child only to age 19)	Not Covered	50% to max of $1,500	50% to max of $1,500	

?! DID YOU KNOW?

Dental Cost Calculator

This cost tool on **www.myuhc.com** shows members the estimated cost for a dental treatment or procedure, and how that cost is impacted by their plan. Members can see what they would be responsible for paying so they can better plan and budget.

Dental DHMO

DENTAL DHMO		Plan 125H	Plan D250H
Code	**Service**	**Copay**	
D0120	Periodic oral evaluation	$0	$0
D0330	Panoramic film	$0	$0
D1110/D1120	Prophylaxis	$0	$0
D2150	Amalgam filling	$0	$0
D2331	Resin composite	$0	$0
D2752	Porcelain crown	$125	$250
D3330	Root canal	$115	$305
D4260	Osseous surgery	$225	$325
D4341	Periodontal scaling	$25	$45
D5110	Complete denture	$150	$275
D6212	Bridge	$125	$250
D7140	Extraction	$0	$0
D9110	Emergency palliative	$5	$10
D8070-90	Orthodontic	$1,895	$1,895

Dental Program Guidelines

PROGRAM GUIDELINES	Dental PPO	Dental HMO
Group Eligibility	Groups currently enrolled with UnitedHealthcare are eligible for adminstration through CoPower.	
Group Size	Groups with 2-4 and 5-100 eligible employees	Groups with 2-100 eligible employees
Eligible Employees	Full time actively at work, non-seasonal, working a minimum of 30 hours per week	
Employer Contribution	• Employer Sponsored: More than 50% of employee premium • Voluntary: No more than 49% of employee premium	
Participation	• Employer Sponsored: 75% after valid waivers, not to fall below 50% of total eligible down to 2 employees • Voluntary without Ortho: At least 2 eligible and minimum of 2 enrolling • Voluntary with Ortho: At least 5 eligible and minimum of 4 enrolling	
Voluntary	Yes, all plans are available on voluntary basis	
Rate Guarantee	12 months	

Product Combinations	• Employer Sponsored Dual Option: Employer must contribute an amount equal to at least 50% of Employee Only premium for the lowest cost plan
	  • Any DHMO/PPO: At least 5 eligible, minimum of 5 enrolling with a minimum of one enrolling in each plan
	  • PPO/PPO: Classic 1000 can be combined with Preferred 1500 or Elite 2000. At least 10 eligible, minimum of 8 enrolling with at least 5 enrolling in the High Plan.
	• Voluntary Dual Option allowed for groups with prior dental coverage
	  • Any DHMO/PPO: minimum of 5 enrolling with a minimum of one enrolling in each plan
	  • PPO/PPO: Classic 1000 + Preferred 1500 or Elite 2000. At least 10 eligible, minimum of 8 enrolling with at least 5 enrolling in the High Plan.	

Ineligible Industries/Loads	None, but industry loads apply	
Waiting Periods	None	
Out-of-State Employees	No more than 49% enrolling may reside outside of CA	Not allowed
Eligible Dependents	Dependent children are eligible until age 26	
Carve-outs	None, Union/Non-union accepted	
1099 Employees	Follows medical rule	
Rollover Benefits	Consumer MaxMultiplier available on all PPO plans	
Implant Coverage	Yes, on PPO and DHMO plans for groups of 5 or more	
Orthodontia	Available on certain plans for groups of 5 or more	Available for groups 2 or more
Open Enrollment	Yes	
Administration Fees	None	

Vision Benefits

For groups 2-100 eligible employees:

VISION COVERAGE	Classic	Preferred	Elite
Plan Code	Vol: VL043 ER Paid: VL363	Vol: V1008 ER Paid: V1020	Vol: VH005 ER Paid: VH001
Expenses (In-Network)			
Annual Copayment	$15 Exam $30 Materials	$10 Exam $25 Materials	$10 Exam $10 Materials
Comprehensive Eye Exam	Covered		
Single-Vision Lenses	Covered		
Bifocal Lenses	Covered		
Trifocal Lenses	Covered		
Lenticular Lenses	Covered		
Frames	$100 allowance	$130 allowance	$150 allowance
Covered Contact Lens Selection	Up to 4 boxes of contact lenses		
All Other Elective Contacts	$105 in allowance		
Medically Necessary Contact Lenses	Covered in full		
Polycarbonate (for dependent children)	Covered in full		
Expenses (Out-of-Network)			
Annual Copayment	N/A	N/A	N/A
Comprehensive Eye Exam	$40*		
Single-Vision Lenses	$40*		
Bifocal Lenses	$60*		
Trifocal Lenses	$80*		
Lenticular Lenses	$80*		
Frames	$45*		
Covered Contact Lens Selection	$105*		
All Other Elective Contacts	$105*		
Medically Necessary Contact Lenses	$210*		
Frequency of Services (Months)			
Eye Exams	12		
Lenses	12		
Frames	24	24	12

As a member, you'll have access to:

Discounted Laser Vision Correction

Get discounts through the Laser Vision Network of America's nationwide network by visiting uhclasik.com

Access to Discounts on Contact Lenses

If you have a contact lens prescription, you can order online for 10% off at uhccontacts.com

Preferred Pricing on Hearing Aids

You can buy high-quality, digital hearing aids at discounted prices, starting at $699 each through hi Healthinnovations™ at www.hihealthinnovations.com[1]

Our network includes private practices and leading retail locations.

America's Best Contacts & Eyeglasses · Costco Optical · Eyeglass World · Walmart Vision Center · For Eyes · Visionworks

[1] hi HealthInnovations™ is an affiliate of UnitedHealthcare Insurance Company.

VISION PROGRAM GUIDELINES	Vision
Group Size	Groups with 2-100 eligible employees
Employer Contribution	• Employer Sponsored: More than 50% of employee premium • Voluntary: No more than 49% of employee premium
Participation	Employer Sponsored and Voluntary: At least 2 eligible and minimum of 1 enrolling, no matter the group size
Voluntary	Yes, available for all vision plans
Rate Guarantee	36 months
Waiting Periods	None
Out-of-State Employees	Yes, up to 49% enrollees may reside outside of California
Eligible Dependents	Dependent children are eligible until age 26
Carve-outs	None
1099 Employees	Follows medical rules
Owner Only Groups	Not allowed
Open Enrollment	Yes
Administration Fee	None

* Reimbursed up to.

Basic Life and Supplemental Life Benefits

Services Included in the Program

Toll-free Beneficiary Services line:
Unlimited phone access to a master's-level counselor, 24 hours a day, 7 days a week

Referral for face-to-face counseling:
Referral to national network of licensed and certified clinicians for up to two grief counseling sessions

Financial services:
Free 30 minute telephone consultation with a financial coach per year/per topic

Legal services:
Free 30-minute telephone or in-person consultation with an attorney for help with wills, probate or other legal concerns. You may retain the same attorney for representation at a discount to their hourly rate.

Information and referral:
Referral to community resources, such as grief support groups, from a database of over 100,000 contacts

Will and Trust Preparation Services
(Provided by Consolidated Legal Concepts, Inc.)

- **Legal library:** Educational articles on a wide range of legal and financial topics, as well as attorneys' answers to frequently asked questions[1]
- **Legal forms**: Standard legal forms for each state covering various legal situations, including estate planning, wills and trusts, living wills and power of attorney
- **Legal tools:** A will and trust preparation tool that helps to create legal documents, including a will or power of attorney
- **Assisted document preparation**: Discounted document-preparation assistance[2]

BASIC LIFE & AD&D COVERAGE	Employee
Guaranteed Issue Amounts	• 6-19 eligible employees: $20,000, $25,000 or $50,000 • 20-50 eligible employees: $25,000, $50,000, $75,000, or $100,000 • 51–100 eligible employees: $25,000, $50,000, $75,000, or $100,000
Available Amounts	• 6-19 eligible employees: $20,000, $25,000 or $50,000 • 20-50 eligible employees: $25,000, $50,000, $75,000, or $100,000 • 51–100 eligible employees: $25,000, $50,000, $75,000, or $100,000
Accelerated Death - Employee only	• Included: 50% to $50,000 • 12 month life expectancy
Dependent Life	• For Guranteed Issue Amount $20,000: Spouse $2,000, Child $1,000 • For Guranteed Issue Amount $25,000-$50,000: Spouse $4,000, Child $2,000 • For Guranteed Issue Amount $75,000-$100,000: Spouse $7,500, Child $3,750
AD&D Amounts – Employee only	Benefit amount matches the Basic Life benefit amount
AD&D Loss Period	90 days
Seatbelt Benefit	10% to $10,000
Employee Class Schedule	Classes not allowed
Age Reduction Schedule	• 65% at age 65 • 50% at age 70

[1] Online reference material provided by Consolidated Legal Concepts, Inc.
[2] Users receive a 10% discount on assisted document-preparation fees. The fee must be paid online with a credit card to initiate the document-preparation process; assisted document-preparation services may incur a minimal cost.

Basic Life and Supplemental Life Benefits & Program Guidelines

SUPPLEMENTAL LIFE & AD&D COVERAGE	Employee
Guaranteed Issue Amounts	• 10–50 eligible employees: $30,000 • 51–100 eligible employees: $50,000-$80,000
Benefit Amount - Flat Benefit	$10,000 to plan maximum in $10,000 increments
Benefit Amount - Salaried Based	1x or 2x salary to the plan maximum
Plan Maximums	• 10-19 eligible employees: $100,000 • 20-50 eligible employees: $200,000 • 51-100 eligible employees: $300,000
Accelerated Death - Employee only	Included: 50% to $50,000
Dependent Life	• Spouse: $10,000 or $20,000 • Child: $5,000 or $10,000
AD&D Amounts - Employee and Dependent	Benefit amount matches the Supplemental Life benefit amount
AD&D Loss Period	90 Days
Seatbelt/Airbag Benefit	• Seatbelt: 10% to $10,000 • Airbag: 10% to $10,000 • Maximum $20,000
Employee Class Schedule	• Classes not available
Age Reduction Schedule (applies to Employee Life and AD&D benefit)	• 65% at age 65 • 50% at age 70

PROGRAM GUIDELINES	
Group Eligibility	• Groups with 6-100 eligible employees for Basic Life • Voluntary Supplemental Life for groups of 10 or more eligible. Must be sold with Basic Life. Automatically includes AD&D • No more than 50% of group can be from same immediate family
Eligible Employees	Full time actively at work, non-seasonal, working a minimum of 30 hours per week
Contribution	• Employer Sponsored (Non-Contributory) Basic Life & AD&D: 100% employer paid • Employer Sponsored (Contributory) Basic Life: 75% employer paid • Voluntary Supplemental and Dependent Life: 100% employee paid
Participation	• Basic Life: 100% of eligible employees • Voluntary Supplemental Life: Minimum participation of 25% of the eligible employees
Rate Guarantee	24 months
Waiting Periods	• The 1st of the month after date of hire • The 1st of the month after 1, 2, or 3 months
Dependent Eligibility	Dependent children are eligible until age 26
Carve-outs	Allowed for management or salaried employees
1099 Employees	Not eligible for coverage
Open Enrollment	None. Offered at initial effective date only

Dental Rates

Voluntary and Employer Sponsored rates based on eligible employees. Rates can be calculated through a quoting system like HealthConnect. Group size will need to be entered for correct rate.

Vision Rates

VISION RATES					
Plan Code	**Contribution Type**	**EE**	**EE/SP**	**EE/CH**	**FAM**
Classic (VL043)	Voluntary	$6.98	$13.24	$15.54	$21.87
Preferred (V1008)	Voluntary	$8.55	$16.23	$19.04	$26.80
Elite (VH005)	Voluntary	$11.44	$21.72	$25.48	$35.86
Employer Sponsored					
Classic (VL363)	50% Employer Paid	$6.44	$12.21	$14.33	$20.15
Preferred (V1020)	50% Employer Paid	$7.44	$14.13	$16.57	$23.32
Elite (VH001)	50% Employer Paid	$9.38	$17.80	$20.88	$29.39

Basic Life & Supplemental Life Rates

BASIC LIFE WITH AD&D RATES	
Eligible Group Size	**Per $1,000 Of Covered Volume**
6-50	$0.27
51-100	$0.24

SUPPLEMENTAL LIFE WITH AD&D RATES	
Age	**Employee and Spouse Monthly Premium Rate Per $1,000 Coverage**
<25	$0.11
25 to 29	$0.12
30 to 34	$0.13
35 to 39	$0.16
40 to 44	$0.22
45 to 49	$0.32
50 to 54	$0.48
55 to 59	$0.80
60 to 64	$1.17
65 to 69	$2.24
70 to 74	$3.81
75 or older	$7.51
Birth to Age 26	$0.33

All rates effective from 04/01/2019 through 09/30/2019.

UnitedHealthcare/ Dental Exclusions & Limitations

Dental Services described in this section are covered when such services are:

A Necessary;

B Provided by or under the direction of a Dentist or other appropriate provider as specifically described;

C The least costly, clinically accepted treatment; and

D Not excluded as described in the Section entitled, General Exclusions.

General Limitations

1. PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.
2. COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to 1 time per consecutive 36 months.
3. BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.
4. EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.
5. DENTAL PROPHYLAXIS Is Covered in combination with periodontal maintenance but not on the same date of service, benefit is not to exceed in combination with periodontal maintenance 4 per consecutive 12 months.
6. FLUORIDE TREATMENTS Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
7. SPACE MAINTAINERS Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
8. SEALANTS Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.
9. RESTORATIONS (Amalgam or Composite) Multiple restorations on one surface will be treated as a single filling.
10. PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.
11. INLAYS AND ONLAYS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
12. CROWNS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
13. POST AND CORES Covered only for teeth that have had root canal therapy.
14. SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.
15. SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.
16. ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.
17. PERIODONTAL MAINTENANCE Is covered in combination with dental prophylaxis but not on the same date of service, benefit is not to exceed in combination with dental prophylaxis 4 per consecutive 12 months.
18. FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
19. PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
20. RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.
21. REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.
22. PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.
23. OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.
24. FULL MOUTH DEBRIDEMENT Limited to 1 time every consecutive 36 months.
25. GENERAL ANESTHESIA Covered only when clinically necessary.
26. OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.
27. PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.
28. REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS AND IMPLANTS, IMPLANT
29. CROWNS, IMPLANT PROTHESIS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

General Exclusions

1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any Dental Procedure not directly associated with dental disease.
6. Any Dental Procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Any implant procedures performed which are not listed as Covered implant procedures in the Schedule of Covered Dental Services.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.

UnitedHealthcare/Dental Exclusions & Limitations (cont.)

13. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
15. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
16. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
17. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
18. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
19. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
20. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
21. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
22. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
23. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
25. Orthodontic Services.
26. Foreign Services are not covered unless required as an Emergency.
27. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
28. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services than x-rays and exam, were performed on the same tooth during the visit.

Vision Exclusions & Limitations

1. Non-prescription items (e.g. Plano lenses) {1other than those listed in the Schedule(s) of Covered Vision Services}.
2. Services that the Covered Person, without cost, obtains from any governmental organization or program.
3. Services for which the Covered Person may be compensated under Workers' Compensation Law, or other similar employer liability law.
4. Any eye examination required by an employer as a condition of employment, by virtue of a labor agreement, a government body, or agency.
5. Medical or surgical treatment for eye disease, which requires the services of a Physician.
6. Expenses incurred prior to meeting the Deductible.
7. Expenses incurred in excess of the Maximum Annual Benefit.
8. Expenses incurred in excess of the Maximum Policy Benefit.
9. {Replacement} {or} {repair} of {lenses} {and/or} {frames} that have been {lost} {or} {broken}.
10. Optional Lens Extras not listed in the Schedule(s) of Covered Vision Services.
11. Missed appointment charges.
12. Applicable sales tax charged on Services.
13. Services that are not specifically covered by the Policy.
14. Procedures that are considered to be Experimental, Investigational or Unproven. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
15. Any Vision Service Covered under an Essential Health Benefit plan is not covered under this Policy.
16. Any Vision Service rendered by the Policyholder.
17. Intraocular lenses.

Basic Life and AD&D Exclusions & Limitations

ACCELERATED DEATH BENEFIT

Limitations: Accelerated Death Benefits will not be payable if:

1. The Covered Person has assigned his Life Insurance Benefits; or
2. We have been notified that all or a portion of the Life Insurance Benefits are to be paid to the Covered Person's former Spouse as part of a divorce agreement; or
3. The Covered Person is required by law to accelerate benefits in order to meet the claims of creditor(s); or
4. The Covered Person is required by a government agency to accelerate benefits in order to qualify for a government benefit or entitlement.

The Accelerated Death Benefit is not available to Retired Covered Persons.

AD&D BENEFIT

Limitations: We will not pay a benefit for a loss caused directly or indirectly by:

1. Disease, bodily or mental infirmity, or medical or surgical Treatment of these;
2. Suicide or intentionally self-inflicted Injury, while sane or insane;
3. Participation in a riot or insurrection, or commission of an assault or felony;
4. War or any act of war, declared or undeclared;
5. Use of any drug, hallucinogen, controlled substance, or narcotic unless prescribed by a Physician;
6. Driving while intoxicated, as defined by the applicable state law where the loss occurred;
7. Engaging in the following hazardous activities, including skydiving, hang gliding, auto racing, mountain climbing, Russian Roulette, autoerotic asphyxiation, or bungee jumping;
8. Injury arising out of or in the course of any occupation or employment for pay or profit, or any Injury or Sickness for which the Covered Person is entitled to benefits under any Workers Compensation Law, Employers Liability Law or similar law, unless this insurance is issued on an occupational (24 hour) basis as shown in the Schedule of Benefits;
9. Travel or flight in, or descent from any aircraft, unless as a fare-paying passenger on a commercial airline flying between established airports on: a) a scheduled route; or b) a charter flight seating 15 or more people.

Supplemental Life and AD&D Exclusions & Limitations

SUPPLEMENTAL LIFE

Limitations: No benefit will be paid for any loss caused directly or indirectly from:

1. Suicide occurring within 24 months after the Covered Person's initial Effective Date of insurance; or
2. Suicide occurring within 24 months after the Effective Date of any increase or additional insurance. This limitation applies only to the increased or additional amount of insurance.

ACCELERATED DEATH BENEFIT

Limitations: Accelerated Death Benefits will not be payable if:

1. The Covered Person has assigned his Life Insurance Benefits; or
2. We have been notified that all or a portion of the Life Insurance Benefits are to be paid to the Covered Person's former Spouse as part of a divorce agreement; or
3. The Covered Person is required by law to accelerate benefits in order to meet the claims of creditor(s); or
4. The Covered Person is required by a government agency to accelerate benefits in order to qualify for a government benefit or entitlement.

The Accelerated Death Benefit is not available to Retired Covered Persons.

AD&D BENEFIT

Limitations: We will not pay a benefit for a loss caused directly or indirectly by:

1. Disease, bodily or mental infirmity, or medical or surgical Treatment of these;
2. Suicide or intentionally self-inflicted Injury, while sane or insane;
3. Participation in a riot or insurrection, or commission of an assault or felony;
4. War or any act of war, declared or undeclared;
5. Use of any drug, hallucinogen, controlled substance, or narcotic unless prescribed by a Physician;
6. Driving while intoxicated, as defined by the applicable state law where the loss occurred;
7. Engaging in the following hazardous activities, including skydiving, hang gliding, auto racing, mountain climbing, Russian Roulette, autoerotic asphyxiation, or bungee jumping;
8. Injury arising out of or in the course of any occupation or employment for pay or profit, or any Injury or Sickness for which the Covered Person is entitled to benefits under any Workers Compensation Law, Employers Liability Law or similar law, unless this insurance is issued on an 24 hour basis as shown in the Schedule of Benefits;
9. Travel or flight in, or descent from any aircraft, unless as a fare-paying passenger on a commercial airline flying between established airports on: a) a scheduled route; or b) a charter flight seating 15 or more people.

UnitedHealthcare Enrollment Checklist

- ☐ United Healthcare Employer Application with CoPower Administration and Plan Selection Form
- ☐ United Heathcare Employee Enrollment form, Census Enrollment spreadsheets, Dental/Vision Enrollment form, or Life Enrollment form
- ☐ DE9/DE9C form, payroll register or prior carrier bill. For groups 10+, Participation Certification Form
- ☐ A company check for the first month's premium made payable to CoPower or a One-Time Debit Authorization Form with a copy of a voided check
- ☐ Copy of the HealthConnect quote

Carrier Contact Information:

UnitedHealthcare

Dental

- www.myuhc.com
- 1.888.679.8925

Vision

- www.myuhcvision.com
- 1.888.679.8925

Plan Administration:

CoPower

1600 W. Hillsdale Blvd.
San Mateo, California 94402
T: 888.920.2322
E: sales@copower.com
www.copower.com

copower™

Benefits made easy

These policies have exclusions, limitations and terms under which the policies may be continued in force or discontinued. For costs and complete details of the coverage, contact UnitedHealthcare Insurance Company.

UnitedHealthcare dental coverage underwritten by UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or their affiliates. Administrative services provided by Dental Benefit Providers, Inc., Dental Benefit Administrative Services (CA only), DBP Services (NY only), United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number DPOL.06.TX and associated COC form number DCOC.CER.06. Plans sold in Virginia use policy form number DPOL.06.VA and associated COC form number DCOC.CER.06.VA.

UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or their affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX or VPOL.13.TX and associated COC form number VCOC.INT.06.TX or VCOC.CER.13.TX. Plans sold in Virginia use policy form number VPOL.06.VA or VPOL.13.VA and associated COC form number VCOC.INT.06.VA or VCOC.CER.13.VA.

This policy has exclusions, limitations and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact either your broker or UnitedHealthcare Insurance Company.

UnitedHealthcare Life products are provided by UnitedHealthcare Insurance Company; and in California by Unimerica Life Insurance Company; UnitedHealthcare Insurance Company is located in Hartford, CT; Unimerica Life Insurance Company is located in Milwaukee, WI.