Aflac Dental Insurance

Benefits Proposal

This proposal has been prepared for:

eP6ix Benefits

Presented by:

Aflac

Proposal State:

West Region

American Family Life Assurance Company of Columbus
Policy Series QN81000

Plan Description

The Aflac Dental Plan gives you something to smile about. Rely on us for access to affordable dental care and more.

Features and Plan Provisions (specific provisions and descriptions may vary by state)	
Benefit Amounts	See benefit schedule for available options
Requirements	eP6ix agrees to write a minimum $500,000 in annual premium and agree to a block renewal strategy for all groups written under the this product offering
Eligibility	Employees who are active full time employees working at least 30 hours per week and have been continuously employed for the duration set by the employer. Seasonal and temporary employee are not eligible. Dependents are eligible, but only if the employee is eligible and participates.
Enrollment Assumptions	Enrollments take place once each 12-month period. Later enrollees cannot enroll outside of an annual enrollment period.
Broker Commissions	10.0% Broker
Number of Eligible Lives	25-199
Participation	Greater of 20% or 10 Enrolled Employees
Rate Guarantee	24 months
Rate Cap(s)	N/A
Effective Date	11/1/2021 and Later
Product Type	PPO Plan
Ineligible Industries	Dental Offices, Dental Services Offices, Non-Traditional Groups (Unions, PEOS, Trusts, Assocations, Etc), Cannabis Related Groups, and Native American Tribes
Benefit Waiting Period	Not Applicable
Nation Wide Excluded States	Alaska, Hawaii, Maryland, Montana, New Jersey, New Mexico, New York, North Carolina, Puerto Rico, and Washington

Plan Benefits Option 1

(Descriptions of specific benefits may vary by state.)

PPO Plan Summary	In-Network / Out-of-Network	In-Network / Out-of-Network
Coverage	**Without Ortho**	**With Ortho**
Deductible	$50 Annual; Max 3 per family (decreases over time)	$50 Annual; Max 3 per family (decreases over time)
Deductible waived for A services	Waived	Waived
Calendar Year	$1000	$1000
Class A - Preventive	100%	100%
Class B - Basic Restorative	80%	80%
Class C - Major Restorative	50%	50%
Class D - Orthodontia	0%	50%
Network Negotiated Fee	Negotiated Fee / 95th Percentile	Negotiated Fee / 95th Percentile
Orthodontia Maximum	Not Covered	$1000
Annual Maximum Carryover	Included	Included
Clear Align Ortho	Not Covered	Included
Accidental Dental Injury	Included	Included

Benefit and Premium Rates

Premiums		
Members/Coverage	**Monthly Rate**	**Monthly Rate**
Employee	$34.99	$34.99
Employee & Spouse	$69.21	$69.21
Employee & Child(ren)	$80.88	$93.09
Family	$115.10	$127.31

Preventive Benefits	Frequency
Cleanings (Prophylaxis)	2 per calendar year
Exams	2 per calendar year
Fluoride treatments	1 per 12 months, Under age 19
Radiographs - Intraoral (Periapical/Occlusal)	1 every 12 months
Radiographs Full Mouth	1 every 36 months
Sealants	1 tooth per 36 months, Under age 19
Space Maintainers	Maximum of 1 each tooh per 24 months, Under Age 19
Emergency Pallative Treatment	

Basic Benefits	Frequency
Restorations Anterior and Posterior (Amalgams & Resin)	Under age 19, replacing existing only if in place for 12 months. Age 19 and over, replace existing only if in place for 36 months.
Endodontics - Root Canal	One per tooth
Pulpotomy	Dependent Children under Age 14
Pulp Capping	
Pulp Therapy	
Apexification & Recalcification	
Periodontal Maintenance	2 per calendar year
Periodontial Scaling & Root Planning	1 per quadrant per 24 months
Periodontal Surgical Extractions	1 per quadrant per 36 months
Simple Extractions (Extraction, erupted tooth or exposed root)	
Surgical Extractions	
Oral Surgery	
Anesthesia	

Major Benefits	Frequency
Onlays	1 per tooth in 5 calendar years
Prefabricated Stainless Steel Crowns	1 per tooth in 5 calendar years
Crowns	1 per tooth in 5 calendar years
Crown Repairs	6 months must have passed since initial placement
Bridges	1 per tooth in 5 calendar years
Bridge Repairs	6 months must have passed since initial placement
Dentures	1 per tooth in 5 calendar years
Denture Repairs	6 months must have passed since initial placement
Implants	1 per tooth in 5 calendar years

Orthodontia Benefits	Frequency	
Orthodontic	Not Covered	Child Only, Under Age 19

Plan Benefits Option 2

(Descriptions of specific benefits may vary by state.)

PPO Plan Summary	In-Network / Out-of-Network	In-Network / Out-of-Network
Coverage	**Without Ortho**	**With Ortho**
Deductible	$50 Annual; Max 3 per family (decreases over time)	$50 Annual; Max 3 per family (decreases over time)
Deductible waived for A services	Waived	Waived
Calendar Year	$1500	$1500
Class A - Preventive	100%	100%
Class B - Basic Restorative	80%	80%
Class C - Major Restorative	50%	50%
Class D - Orthodontia	0%	50%
Network Negotiated Fee	Negotiated Fee / 95th Percentile	Negotiated Fee / 95th Percentile
Orthodontia Maximum	Not Covered	$1500
Annual Maximum Carryover	Included	Included
Clear Align Ortho	Not Covered	Included
Accidental Dental Injury	Included	Included

Benefit and Premium Rates

Premiums		
Members/Coverage	**Monthly Rate**	**Monthly Rate**
Employee	$37.84	$37.84
Employee & Spouse	$74.91	$74.91
Employee & Child(ren)	$84.22	$96.43
Family	$121.29	$133.50

Preventive Benefits	Frequency
Cleanings (Prophylaxis)	2 per calendar year
Exams	2 per calendar year
Fluoride treatments	1 per 12 months, Under age 19
Radiographs - Intraoral (Periapical/Occlusal)	1 every 12 months
Radiographs Full Mouth	1 every 36 months
Sealants	1 tooth per 36 months, Under age 19
Space Maintainers	Maximum of 1 each tooh per 24 months, Under Age 19
Emergency Pallative Treatment	

Basic Benefits	Frequency
Restorations Anterior and Posterior (Amalgams & Resin)	Under age 19, replacing existing only if in place for 12 months. Age 19 and over, replace existing only if in place for 36 months.
Endodontics - Root Canal	One per tooth
Pulpotomy	Dependent Children under Age 14
Pulp Capping	
Pulp Therapy	
Apexification & Recalcification	
Periodontal Maintenance	2 per calendar year
Periodontial Scaling & Root Planning	1 per quadrant per 24 months
Periodontal Surgical Extractions	1 per quadrant per 36 months
Simple Extractions (Extraction, erupted tooth or exposed root)	
Surgical Extractions	
Oral Surgery	
Anesthesia	

Major Benefits	Frequency
Onlays	1 per tooth in 5 calendar years
Prefabricated Stainless Steel Crowns	1 per tooth in 5 calendar years
Crowns	1 per tooth in 5 calendar years
Crown Repairs	6 months must have passed since initial placement
Bridges	1 per tooth in 5 calendar years
Bridge Repairs	6 months must have passed since initial placement
Dentures	1 per tooth in 5 calendar years
Denture Repairs	6 months must have passed since initial placement
Implants	1 per tooth in 5 calendar years

Orthodontia Benefits	Frequency	
Orthodontic	Not Covered	Child Only, Under Age 19

Plan Benefits Option 3

(Descriptions of specific benefits may vary by state.)

PPO Plan Summary	In-Network / Out-of-Network	In-Network / Out-of-Network
Coverage	**Without Ortho**	**With Ortho**
Deductible	$50 Annual; Max 3 per family (decreases over time)	$50 Annual; Max 3 per family (decreases over time)
Deductible waived for A services	Waived	Waived
Calendar Year	$2000	$2000
Class A - Preventive	100%	100%
Class B - Basic Restorative	80%	80%
Class C - Major Restorative	50%	50%
Class D - Orthodontia	0%	50%
Network Negotiated Fee	Negotiated Fee / 95th Percentile	Negotiated Fee / 95th Percentile
Orthodontia Maximum	Not Covered	$1500
Annual Maximum Carryover	Included	Included
Clear Align Ortho	Not Covered	Included
Accidental Dental Injury	Included	Included

Benefit and Premium Rates

Premiums		
Members/Coverage	**Monthly Rate**	**Monthly Rate**
Employee	$39.30	$39.30
Employee & Spouse	$77.83	$77.83
Employee & Child(ren)	$85.91	$103.01
Family	$124.44	$141.54

Preventive Benefits	Frequency
Cleanings (Prophylaxis)	2 per calendar year
Exams	2 per calendar year
Fluoride treatments	1 per 12 months, Under age 19
Radiographs - Intraoral (Periapical/Occlusal)	1 every 12 months
Radiographs Full Mouth	1 every 36 months
Sealants	1 tooth per 36 months, Under age 19
Space Maintainers	Maximum of 1 each tooh per 24 months, Under Age 19
Emergency Pallative Treatment	

Basic Benefits	Frequency
Restorations Anterior and Posterior (Amalgams & Resin)	Under age 19, replacing existing only if in place for 12 months. Age 19 and over, replace existing only if in place for 36 months.
Endodontics - Root Canal	One per tooth
Pulpotomy	Dependent Children under Age 14
Pulp Capping	
Pulp Therapy	
Apexification & Recalcification	
Periodontal Maintenance	2 per calendar year
Periodontial Scaling & Root Planning	1 per quadrant per 24 months
Periodontal Surgical Extractions	1 per quadrant per 36 months
Simple Extractions (Extraction, erupted tooth or exposed root)	
Surgical Extractions	
Oral Surgery	
Anesthesia	

Major Benefits	Frequency
Onlays	1 per tooth in 5 calendar years
Prefabricated Stainless Steel Crowns	1 per tooth in 5 calendar years
Crowns	1 per tooth in 5 calendar years
Crown Repairs	6 months must have passed since initial placement
Bridges	1 per tooth in 5 calendar years
Bridge Repairs	6 months must have passed since initial placement
Dentures	1 per tooth in 5 calendar years
Denture Repairs	6 months must have passed since initial placement
Implants	1 per tooth in 5 calendar years

Orthodontia Benefits	Frequency	
Orthodontic	Not Covered	Child Only, Under Age 19

Orthodontic Benefit

We will pay a benefit for the following Orthodontic services:
- Initial orthodontic examination;
- Initial placement of braces or appliances; and
- Continuing treatment for braces or appliances

We will pay an initial benefit for covered Orthodontic services related to the initial Orthodontic treatment, which consists of:
a) diagnosis;
b) evaluation;
c) pre-care; and
d) insertion of bands or appliances up to 25% of the maximum lifetime benefit.
After the payment for the initial orthodontic treatment, benefits for covered orthodontic services will be paid in equal monthly installments over the course of the remaining orthodontic treatment, up to 75% of the maximum lifetime benefit. The subsequent monthly payments will be made only if your dependent remains insured under the certificate and provides proof that the orthodontic treatment continues.

Orthodontic Benefit Limitations

- If orthodontic treatment continues after the maximum lifetime benefit has been paid, no further benefits will be paid.
- Orthodontic services must begin while the policy is in force. No payments will be made for orthodontic treatment if the appliances or bands are inserted prior to becoming insured except as provided in the takeover of existing coverage provision.
- We consider orthodontic treatment to be started on the date the bands or appliances are inserted. Any other orthodontic treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the orthodontic treatment is rendered.
- Orthodontic Services does include treatment with clear aligners; covered at up to 100% of the Maximum Lifetime Benefit. Orthodontic Services for braces or appliances and Orthodontic Services for clear aligners are not payable for the same Insured Person

Maximum Carryover Benefit Limitations:

- Carryover Amount: $250
- Threshold Limit: $500
- Maximum Carryover Bank: $1000

- This benefit allows insured plan members to carryover $250 each calendar year, if:
    - An insured submits at least one qualifying claim for Preventive/Type A dental expense incurred during the calendar year and/or
    - At least one qualifying claim for any other class of dental services in excess of applicable deductible, co-pay fees, and
    - The total benefit amount paid stays below $500 for that calendar year

Accidental Dental Injury:

The covered dental Injury is an injury to a Sound Natural Tooth, sustained while the Insured Person is insured under the Policy, and which is caused solely by a sudden violent act or accident which could not be predicted in advance or avoided. No Member coinsurance, and/or deductible, or waiting period will apply to services received as a result of the accident

Benefit Descriptions, Limitations & Exclusions

Benefit descriptions, limitations and exclusions vary by state. Please see the master policy for full and complete information. All benefit descriptions, limitations and exclusions appear regardless of the benefit options chosen. Appearance of benefit descriptions, limitations or exclusions does not necessarily indicate inclusion of the corresponding benefits in your plan design.

Limitations & Exclusions

We will not pay benefits if you fail to cooperate with our investigation into the validity of your claim. No benefits are payable under the policy for the services listed below. In addition, the services listed below will not be recognized toward the satisfaction of any deductible:

- Any services which are not included in the Schedule of Covered Procedures;
- Any service started or appliance installed before the effective date or after the date coverage terminates, except as provided in the "takeover of existing coverage" section of the certificate;
- Any service, which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years, as determined by us;
- Any procedure we determine is not necessary, does not offer a favorable prognosis, does not have uniform professional endorsement or is experimental in nature;
- Crowns, inlays, onlays, cast restorations, or other laboratory prepared restorations on teeth, which may be satisfactorily restored with an amalgam or composite resin filling;
- Any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations unless such procedure is listed in the Schedule of Covered Procedures;
- Appliances, services or procedures relating to: (1) the change or maintenance of vertical dimension; (2) restoration of occlusion (unless otherwise noted in the schedule of covered procedures— only for occlusal guards); (3) splinting; (4) correction of attrition, abrasion, erosion or abfraction; (5) bite registration or (6) bite analysis;
- Replacement of bridges unless the bridge is older than the age allowed in the schedule of covered procedures and cannot be made serviceable;
- Replacement of full or partial dentures unless the prosthetic appliance is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
- Replacement of crowns, inlays or onlays unless the prior restoration is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
- For orthodontic treatment unless otherwise listed as a covered procedure in the Schedule of Covered Procedures;
- Services provided for any type of temporomandibular joint (tmj) dysfunctions, muscular, skeletal deficiencies involving tmj or related structures, myofascial pain unless such procedure is listed as a covered procedure in the Schedule of Covered Procedures;
- Charges for implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized services or attachments unless such procedures are listed as covered procedures in the Schedule of Covered Procedures;
- Athletic mouth guards; myofunctional therapy; treatment for malignancies, cysts and neoplasms; failure to keep scheduled appointment; charges for completion of claim forms; infection control; precision or semi-precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; charges for travel time; transportation costs; professional advice; treatment of jaw fractures; orthographic surgery; exams required by a third party other than us; personal supplies (e.g., waterpik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;
- Prescription drugs, premedication, pharmaceuticals, or analgesia;
- Dental disease, defect or injury caused by a declared or undeclared war or any act of war or terrorism or taking part in an insurrection or riot; the commission or attempted commission of a crime; an intentionally self-inflicted injury or attempted suicide while sane or insane;
- Dental treatment not approved by the American Dental Association or which is clearly experimental in nature;
- Any charge for a service for which benefits are available under worker's compensation or an occupational disease act or law, even if the insured person did not purchase the coverage that is available to him;
- Any charge for a service performed outside of the United States other than for emergency treatment. Benefits for emergency treatment performed outside of the United States are limited to a maximum of $100 per year;
- Services performed by a dentist who is a member of the insured person's family. Insured person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents;
- The initial placement of a removable full denture or a removable partial denture unless it includes the replacement of a functioning natural tooth extracted while the person is insured under the policy;
- The initial placement of a fixed partial denture including a Maryland bridge, unless it includes the replacement of a functioning natural tooth extracted while the person is insured under the policy, provided that tooth was not an abutment to an existing partial denture that is less than five years old or to an existing fixed partial denture or Maryland bridge which is less than seven years old or other frequency limitation as stated in Schedule of Covered Procedures. Benefits are payable only for the replacement of those teeth which were extracted while the person was insured under the policy;
- The replacement of teeth beyond the normal complement of 32;
- The replacement of an existing removable partial denture with a fixed partial denture unless upgrading to a fixed partial denture is essential to the correction of the insured person's dental condition;
- Local anesthetic as a separate fee;
- Any treatment plan which involves full-mouth reconstruction by the removal and reestablishment of occlusal contacts of 10 or more teeth with restorations, crowns, onlays, inlays, fixed partial dentures, dentures, or any combination of these services; and
- Any Services (except emergency treatment with a covered procedure or a covered procedure performed in a limited access area) provided by a non-participating provider, if the policyholder has selected and in-network only plan

Notices

This proposal is a brief description of coverage, not a contract. Read your master policy carefully for exact plan language, terms, and conditions. This is a limited benefit plan and provides dental benefits only. Aflac's contracts of insurance, including Aflac's network dental and vision plans, provide limited-scope and/or supplemental benefits only and do not constitute comprehensive health insurance coverage. Aflac's contracts of insurance do not satisfy the requirement of minimum essential coverage under the Patient Protection and Affordable Care Act (ACA) and are not designed to meet any of the essential health benefit requirements mandated by the ACA or federal law, including pediatric oral or vision care services. Aflac's contracts of insurance are not an alternative to, or a substitute for, comprehensive health insurance coverage and should only be used to supplement comprehensive health insurance coverage.

Coverage is underwritten by American Family Life Assurance Company of Columbus (Aflac). Worldwide Headquarters
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