Aflac Vision Insurance

Benefits Proposal

This proposal has been prepared for:

ePSix Benefits

Presented by:

Aflac

Proposal State:

SouthEast Region including Georgia

American Family Life Assurance Company of Columbus
Policy Series QNV1000

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 / 51+ for Florida
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	Davis Vision - Voluntary
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, Disctrict of Columbia, Hawaii, Maryland, Montana, New Jersey, New Mexico, New York, North Carolina, Puerto Rico, Virginia, and Washington

Plan Benefits

(Descriptions of specific benefits may vary by state.)

In-Network Benefits (Network Available at www.davisvision.com)	Aflac Plan 4
Service Type	**Frequency - Once Every:**
Eye Examinations with Dilation (as necessary)	12 Months
Spectacle Lenses	12 Months
Frame	24 Months
Contact Lens (In lieu of eyeglasses)	12 Months
In Network	
Eye Examination	$10
Spectacle Lenses	$25
Contact Lens Evaluation, Fitting & Follow-Up Care	$0
Eyeglass Benefit - Frame	
Frame Allowance (Retail)	Up to $130 or Up to $180 at Visionworks
Davis Vision Frame Collection (in Lieu of Allowance)	**Member Co-Pays**
Fashion level	$0
Designer level	$0
Premier level	$25
Eyeglass Benefits - Spectacle Lenses	**Member Co-Pays**
Clear plastic lenses in any RX (Single Vision, Bifocal, Trifocal, Lenticular)	$0
Tinting of Plastic Lenses	$0
Scratch Resistant Coating	$0
Polycarbonate Lenses (Children/Adults)	$0/$30
Ultraviolet Coating	$12
Anti-Reflective (AR) Coating (Standard/Premier/Ultra/Ultimate)	$35/$48/$60/$85
Progressive Lenses (Standard/Premium/Ultra/Ultimate)	$50/$90/$140/$175
High Index Lenses	$55
Polarized Lenses	$75
Plastic Photochromic Lenses	$65
Scratch Protection Plan: Single Vision/Multifocal Lenses	$20/$40
Contact Lens Benefit (in lieu of eyeglasses)	
Contact Lens Material Allowance Plus a 15% discount on any overage	Up to $130
Evaluation, Fitting & Follow Up Care - Standard Lens Types	15% Discount
Evaluation, Fitting & Follow Up Care - Specialty Lens Types	15% Discount
Collection Contact Lenses Benefit (in Lieu of Contact Lens Material Allowance)	
Materials Disposable: up to	4 boxes/multi-packs
Planned Replacement: up to	2 boxes/multi-packs
Evaluation, Fitting & Follow Up Care	$0 Copay
Non-Elective Contact Lenses (with Prior Approval)	
Materials, Evaluation, Fitting & Follow Up Care	$0 Copay
Service Type	**Out-of-Network Frequency**
Eye Examination:	12 Months
Lenses:	12 Months
Frames:	24 Months
Out-of-Network Reimbursement Allowance Schedule: Up to	
Eye Examination	Up to $40
Frame	Up to $50
Lenses - Single Vision	Up to $40
Lenses - Bifocal/Progressive	Up to $60
Lenses - Trifocal	Up to $80
Lenses - Lenticular	Up to $100
Elective Contact Lenses	$105
Visually Required Contact Lenses	$225

Premiums	
Members/Coverage	**Monthly Premiums**
Employee	$7.55
Employee & Spouse	$15.09
Employee & Child(ren)	$15.31
Family	$22.14

Plan Benefits

(Descriptions of specific benefits may vary by state.)

In-Network Benefits (Network Available at www.davisvision.com)	Aflac Plan 6
Service Type	**Frequency - Once Every:**
Eye Examinations with Dilation (as necessary)	**12 Months**
Spectacle Lenses	**12 Months**
Frame	**12 Months**
Contact Lens (In lieu of eyeglasses)	**12 Months**
In Network	
Eye Examination	**$10**
Spectacle Lenses	**$10**
Contact Lens Evaluation, Fitting & Follow-Up Care	**$0**
Eyeglass Benefit - Frame	
Frame Allowance (Retail)	**Up to $150 or Up to $200 at Visionworks**
Davis Vision Frame Collection (in Lieu of Allowance)	**Member Co-Pays**
Fashion level	**$0**
Designer level	**$0**
Premier level	**$0**
Eyeglass Benefits - Spectacle Lenses	**Member Co-Pays**
Clear plastic lenses in any RX (Single Vision, Bifocal, Trifocal, Lenticular)	**$0**
Tinting of Plastic Lenses	**$0**
Scratch Resistant Coating	**$0**
Polycarbonate Lenses (Children/Adults)	**$0/$30**
Ultraviolet Coating	**$12**
Anti-Reflective (AR) Coating (Standard/Premier/Ultra/Ultimate)	**$35/$48/$60/$85**
Progressive Lenses (Standard/Premium/Ultra/Ultimate)	**$50/$90/$140/$175**
High Index Lenses	**$55**
Polarized Lenses	**$75**
Plastic Photochromic Lenses	**$65**
Scratch Protection Plan: Single Vision/Multifocal Lenses	**$20/$40**
Contact Lens Benefit (in lieu of eyeglasses)	
Contact Lens Material Allowance Plus a 15% discount on any overage	**Up to $150**
Evaluation, Fitting & Follow Up Care - Standard Lens Types	**$0**
Evaluation, Fitting & Follow Up Care - Specialty Lens Types	**Up to $60 allowance plus a 15% discount on any overages**
Collection Contact Lenses Benefit (in Lieu of Contact Lens Material Allowance)	
Materials Disposable: up to	**8 boxes/multi-packs**
Planned Replacement: up to	**4 boxes/multi-packs**
Evaluation, Fitting & Follow Up Care	**$0 Copay**
Non-Elective Contact Lenses (with Prior Approval)	
Materials, Evaluation, Fitting & Follow Up Care	**$0 Copay**
Service Type	**Out-of-Network Frequency**
Eye Examination:	**12 Months**
Lenses:	**12 Months**
Frames:	**12 Months**
Out-of-Network Reimbursement Allowance Schedule: Up to	
Eye Examination	**Up to $40**
Frame	**Up to $50**
Lenses - Single Vision	**Up to $40**
Lenses - Bifocal/Progressive	**Up to $60**
Lenses - Trifocal	**Up to $80**
Lenses - Lenticular	**Up to $100**
Elective Contact Lenses	**$105**
Visually Required Contact Lenses	**$225**

Premiums	
Members/Coverage	**Monthly Premiums**
Employee	**$9.20**
Employee & Spouse	**$18.40**
Employee & Child(ren)	**$18.46**
Family	**$26.80**

Plan Benefits

(Descriptions of specific benefits may vary by state.)

In-Network Benefits (Network Available at www.davisvision.com)	Aflac Plan 3
Service Type	**Frequency - Once Every:**
Eye Examinations with Dilation (as necessary)	**12 Months**
Spectacle Lenses	**12 Months**
Frame	**12 Months**
Contact Lens (In lieu of eyeglasses)	**12 Months**
In Network	
Eye Examination	**$10**
Spectacle Lenses	**$10**
Contact Lens Evaluation, Fitting & Follow-Up Care	**$0**
Eyeglass Benefit - Frame	
Frame Allowance (Retail)	**Up to $180 or Up to $230 at Visionworks**
Davis Vision Frame Collection (in Lieu of Allowance)	**Member Co-Pays**
Fashion level	**$0**
Designer level	**$15**
Premier level	**$40**
Eyeglass Benefits - Spectacle Lenses	**Member Co-Pays**
Clear plastic lenses in any RX (Single Vision, Bifocal, Trifocal, Lenticular)	**$0**
Tinting of Plastic Lenses	**$0**
Scratch Resistant Coating	**$0**
Polycarbonate Lenses (Children/Adults)	**$0/$30**
Ultraviolet Coating	**$12**
Anti-Reflective (AR) Coating (Standard/Premier/Ultra/Ultimate)	**$35/$48/$60/$85**
Progressive Lenses (Standard/Premium/Ultra/Ultimate)	**$50/$90/$140/$175**
High Index Lenses	**$55**
Polarized Lenses	**$75**
Plastic Photochromic Lenses	**$65**
Scratch Protection Plan: Single Vision/Multifocal Lenses	**$20/$40**
Contact Lens Benefit (in lieu of eyeglasses)	
Contact Lens Material Allowance Plus a 15% discount on any overage	**Up to $180**
Evaluation, Fitting & Follow Up Care - Standard Lens Types	**$0**
Evaluation, Fitting & Follow Up Care - Specialty Lens Types	**Up to $60 plus 15% discount on overage**
Collection Contact Lenses Benefit (in Lieu of Contact Lens Material Allowance)	
Materials Disposable: up to	**8 boxes/multi-packs**
Planned Replacement: up to	**4 boxes/multi-packs**
Evaluation, Fitting & Follow Up Care	**$0 Copay**
Non-Elective Contact Lenses (with Prior Approval)	
Materials, Evaluation, Fitting & Follow Up Care	**$0 Copay**
Service Type	**Out-of-Network Frequency**
Eye Examination:	**12 Months**
Lenses:	**12 Months**
Frames:	**24 Months**
Out-of-Network Reimbursement Allowance Schedule: Up to	
Eye Examination	**Up to $40**
Frame	**Up to $50**
Lenses - Single Vision	**Up to $40**
Lenses - Bifocal/Progressive	**Up to $60**
Lenses - Trifocal	**Up to $80**
Lenses - Lenticular	**Up to $100**
Elective Contact Lenses	**$105**
Visually Required Contact Lenses	**$225**

Premiums	
Members/Coverage	**Monthly Premiums**
Employee	**$10.08**
Employee & Spouse	**$20.17**
Employee & Child(ren)	**$20.23**
Family	**$29.38**

Plan Benefits

(Descriptions of specific benefits may vary by state.)

In-Network Benefits (Network Available at www.davisvision.com)	Aflac Plan 8
Service Type	**Frequency - Once Every:**
Eye Examinations with Dilation (as necessary)	**12 Months**
Spectacle Lenses	**12 Months**
Frame	**12 Months**
Contact Lens (In lieu of eyeglasses)	**12 Months**
In Network	
Eye Examination	**$0**
Spectacle Lenses	**$0**
Contact Lens Evaluation, Fitting & Follow-Up Care	**$0**
Eyeglass Benefit - Frame	
Frame Allowance (Retail)	**Up to $200 or Up to $250 at Visionworks**
Davis Vision Frame Collection (in Lieu of Allowance)	**Member Co-Pays**
Fashion level	**Covered**
Designer level	**Covered**
Premier level	**Covered**
Eyeglass Benefits - Spectacle Lenses	**Member Co-Pays**
Clear plastic lenses in any RX (Single Vision, Bifocal, Trifocal, Lenticular)	**Covered**
Tinting of Plastic Lenses	**Covered**
Scratch Resistant Coating	**Covered**
Polycarbonate Lenses (Children/Adults)	**$0/$30**
Ultraviolet Coating	**$12**
Anti-Reflective (AR) Coating (Standard/Premier/Ultra/Ultimate)	**$35/$48/$60/$85**
Progressive Lenses (Standard/Premium/Ultra/Ultimate)	**$50/$90/$140/$175**
High Index Lenses	**$55**
Polarized Lenses	**$75**
Plastic Photochromic Lenses	**$65**
Scratch Protection Plan: Single Vision/Multifocal Lenses	**$20/$40**
Contact Lens Benefit (in lieu of eyeglasses)	
Contact Lens Material Allowance Plus a 15% discount on any overage	**Up to $200**
Evaluation, Fitting & Follow Up Care - Standard Lens Types	**$0**
Evaluation, Fitting & Follow Up Care - Specialty Lens Types	**Up to $60 allowance plus a 15% discount on any overages**
Collection Contact Lenses Benefit (in Lieu of Contact Lens Material Allowance)	
Materials Disposable: up to	**8 boxes/multi-packs**
Planned Replacement: up to	**4 boxes/multi-packs**
Evaluation, Fitting & Follow Up Care	**Covered**
Non-Elective Contact Lenses (with Prior Approval)	
Materials, Evaluation, Fitting & Follow Up Care	**Covered**
Service Type	**Out-of-Network Frequency**
Eye Examination:	**12 Months**
Lenses:	**12 Months**
Frames:	**12 Months**
Out-of-Network Reimbursement Allowance Schedule: Up to	
Eye Examination	**Up to $40**
Frame	**Up to $50**
Lenses - Single Vision	**Up to $40**
Lenses - Bifocal/Progressive	**Up to $60**
Lenses - Trifocal	**Up to $80**
Lenses - Lenticular	**Up to $100**
Elective Contact Lenses	**$105**
Visually Required Contact Lenses	**$225**

Premiums	
Members/Coverage	**Monthly Premiums**
Employee	**$11.83**
Employee & Spouse	**$23.67**
Employee & Child(ren)	**$23.68**
Family	**$34.43**

LIMITATIONS, AND EXCLUSIONS

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

Eyeglass lenses and frames are paid in lieu of the contact lenses benefit.

Contact lenses are payable in lieu of eyeglass lenses and frames.

Coverage for a late entrant or re-enrollee is limited to the vision exam benefit during the first 24 months after such person's effective date of coverage.

Dilation is covered in full under the vision exam benefit only if required by state law or done for one of the following conditions: central vision loss, photopsia, floaters, high myopia, diabetes or history of ocular surgery, ocular trauma or ocular disease.

EXCLUSIONS

No benefits are payable for any of the following conditions, services, procedures and/or materials, unless otherwise specifically listed as a covered benefit in the Schedule of Benefits:

- Replacement frames and/or lenses, except at normal intervals when covered services or materials are otherwise available;
- Plano lens or non-prescription lenses or sunglasses;
- Orthoptics, vision training and any associated supplemental testing;
- Frame cases;
- Low (subnormal) vision aids or aniseikonic lenses;
- Medical and surgical treatment of the eyes;
- Charges incurred after (a) the policy ends; or (b) the insured person's coverage under the policy ends, except as stated in the policy;
- Any eye examination or corrective eyewear required by an employer as a condition of employment;
- Services and materials provided by another vision plan except for coordination of benefits;
- Services for which benefits are paid by worker's compensation;
- Benefits provided under the employee's medical insurance except for coordination of benefits;
- Blended bifocal lenses;
- Groove, drill or notch, and roll and polish;
- Two pairs of glasses, in lieu of bifocals, trifocals or progressives;
- Coating on lenses (factory scratch coat, anti-reflective, sunglass colors, etc.);
- Cosmetic items;
- Faceted lenses;
- High-index lenses;
- Laminated lenses;
- Oversize lenses – any lens with an eye size of 61mm or greater;
- Photochromic (transition) lenses;
- Polaroid lenses;
- Polished bevel lenses;
- Polycarbonate lenses, except for insured members under 19;
- Prism lenses;
- Slab-off lenses;
- Tints (except pink tint #1 and #2);
- Ultra-violet tint or coating;
- Additional cost for contact lenses over the allowance;
- Additional cost for a frame over the allowance;
- Progressive power lenses;

No benefits are payable for services performed by 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.

Notices

This proposal is a brief description of coverage, not a contract. Read your policy and riders (as applicable) carefully for exact plan language, terms, and conditions.

This is a limited benefit plan and provides vision 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 | 1932 Wynnton Road | Columbus, Georgia 31999