Aflac Dental Insurance

Plan benefit highlights for: State of Missouri

Group Number: AFCA2004609
Effective Date: 06/01/2023

******Plans are not sponsored or endorsed by the State of Missouri*******

Eligibility	Employees working 30 hours or more per week		
Deductibles	**In Network:** $25 annually Waived for preventive services		
	Out of Network: $25 annually Waived for preventive services		
Maximums	**In Network:** $1,250		
	Out of Network: $1,250		
Maximum carryover benefit	Additional: $1,000 towards annual maximum benefit. Those carryover benefits may be used for any covered dental procedures. This benefit allows insured plan members to carryover $250 each calendar year, if an insured submits at least one qualifying claim for Class A dental expenses incurred during the calendar year, and/or at least one qualifying claim for any other Class dental expense in excess of applicable deductible or co-pay fees, and the total benefit amount paid stays below $500 for that calendar year.		
Network Negotiated Fee	**In Network: Negotiated Fee Schedule** **Out of Network: 90th Percentile**		
Waiting period(s)	**Preventive: 0 months**	**Basic: 0 months**	**Major: 0 Months**

Benefits and covered services	Network Dentist	Non-network Dentist
PREVENTIVE AND DIAGNOSTIC SERVICES • Routine exams (two per year) • Routine cleanings (two per year;one additional cleaning if recommended by a medical doctor due to an underlying medical condition) • Fluoride treatments (one per 12 months for children under age 14) • Sealants (one per 60 months for children under age 14) • Space maintainers (one per tooth per 24 months for children under age 14) • Bitewing x-rays (one per 12 months)	100%	100%
BASIC SERVICES • Emergency palliative treatment • Full-mouth x-rays (one every 36 months) • Fillings (amalgam, anterior resin, posterior resin; replace existing only if in place for 24 months) • Simple extractions (extraction, erupted tooth or exposed root) • Surgical extractions • Oral surgery • Endodontics - Root Canal (one per tooth) • Pulpotomy (under age 14) • Pulp Capping • Pulp Therapy • Periodontal Maintenance (two per year) • Periodontal Scaling & Root Planing (one per quadrant per 24 months) • Periodontal surgical extractions (one per quadrant per 36 months)	80%	80%

Underwritten by:
American Family Life Assurance Company of Columbus
Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999 | 1.855.819.1873

MAJOR SERVICES • Inlays,onlays,crowns,prefabricated stainless steel crowns,bridges and dentures (one per tooth in 5 calendar years) • Crown, bridge and denture repair (6 months must have passed since initial placement) • Anesthesia	50%	50%
DENTAL ACCIDENTAL INJURY BENEFIT	Coinsurance increased to 100% for covered dental injuries.	

Monthly rates		
Employee	Employee + 1 Dependent	Employee + Family
$26.87	$50.49	$78.68

24/7 Online access	Customer care center	Claims address
www.aflac.com/DentalNetwork	**1-855-819-1873**	**Aflac Dental and Vision Attn: Claims PO Box 211276 Eagan, MN 55121**

We make it easy to find a provider! You can visit www.aflac.com/DentalNetwork and click “Provider Search” or call Aflac directly at **1.855.819.1873.**

If you have dental coverage under more than one plan, your benefits may be coordinated.Benefits and/or premiums may vary based on the state and benefit option selected. The plan has limitations and exclusions that may affect benefits payable. Refer to the policy and certificate for complete benefit details, definitions, limitations and exclusions. This is a brief description of coverage and is not a contract. Read your certificate carefully for exact terms and conditions as well as a complete list of the schedule of dental procedures payable under the plan.

LIMITATIONS AND 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; orthognathic 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 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;
• Dental treatment not approved by the American Dental Association or which is clearly experimental in nature;
• Coverage for injuries or illnesses arising out of or in the course of employment or an occupation for wage, profit, or gain;
• 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 an in-network only plan.

NOTICE: The coverage offered is not a qualified health plan (QHP) under the Patient Protection and Affordable Care Act (ACA) and is not required to satisfy essential health benefits mandates of the ACA. The coverage provides limited benefits.

Applies to Policy Series QN81000.