2023

Aflac Group Dental Network Access Plan

COLORADO

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (“AFLAC”)

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Introduction

American Family Life Assurance Company of Columbus ("Aflac") establishes a written Access Plan for its participating provider network servicing its members. The network consists of access to providers contracted with DenteMax, LLC (DenteMax), NovaNet (which uses the Connection Dental Network), Zelis, and Aflac Benefits Solutions, Inc. ("ABS") (collectively the "Network"). Aflac has access to the full networks offered by the Network; Aflac Group Dental members have access to all providers within the Network. The ABS dental network is currently expanding by recruiting daily to provide adequate providers for members.

This Access Plan contains information regarding the accessibility and availability of participating providers within the Network, as well as information on the quality and type of services available to Aflac Group Dental members. This Access Plan is also available online at https://www.aflacbenefitssolutions.com/. Scroll down to the bottom of the website and you will find it under Legal & Miscellaneous. For more information, please contact the Vice President of Network Development and Credentialing, Greg Grocholski, at 813-440-4965, or write to Aflac Benefits Solutions, Inc., Attn: VP of Network Development, 4211 West Boy Scout Blvd., Suite 295, Tampa, FL 33607.

Network Leasing

Aflac has contracted with ABS, formerly known as Argus Dental & Vision, a dental benefits manager and affiliate of Aflac, to administer the Aflac Group Dental program. ABS contracts with DenteMax, NovaNet, and Zelis through network leasing arrangements to access their contracted providers. Aflac and ABS periodically monitor the Network to ensure the standards agreed upon are satisfactorily being met.

DenteMax, NovaNet, and Zelis are responsible for credentialing the Network providers and are expected to comply with all state regulations. ABS has oversight responsibility to ensure the credentialing and quality assurance standards are consistent with those required by the state and those established by ABS and Aflac. A delegated credentialing audit is performed for each network on an annual basis.

Aflac retains oversight responsibility of all services delegated to ABS.

Criteria Used to Build Network

We consider many factors when adding providers to our network. Every provider must be licensed, maintain adequate professional liability insurance, operate in compliance with all laws and regulations, comply with state board orders, complete all credentialing and recredentialing requirements, and comply with our provider agreements, policies and procedures.

Network Adequacy and Corrective Action Process

Network Adequacy

Aflac's dental network meets Colorado's adequacy requirements. Aflac's dental plan provides access to at least one dental provider for at least 90% of our customers within the maximum road travel distance required for each county. Colorado designates each county as one of five geographic types or classifications:

	Geographic Type				
The plan provides access to at least one dental provider for at least 90% of the enrollees	**Large Metro**	**Metro**	**Micro**	**Rural**	**CEAC (Counties with Extreme Access Considerations)**
	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)
Dental Plan Provider	15	30	60	75	110

The size and location(s) of the Network may be presented to an eligible group prior to the sale of the Aflac Group Dental Plan. ABS will monitor the availability of providers in the Network by analyzing statistics indicating current employee locations and provider utilization. Monitoring is done monthly through GEO-Access reports that compare the number of providers to the number of members/employees in a given county.

Members may request that Aflac send network provider recruitment information to their current providers. Aflac will communicate any recruitment requests received to ABS for notice to the Network.

Specialty Care Providers

Aflac requires the Network to contract with independent dental specialists to ensure members have adequate access to specialty care. Contracted specialists include oral surgeons, orthodontists, periodontists, pediatric dentists, prosthodontists, and endodontists.

Members are not required to obtain a referral in order to receive specialty care; members are free to discuss treatment options with their general dentist. The specialist network is monitored on a regular basis to determine if additional specialist offices are needed.

Corrective Action Process

If a network adequacy issue exists, Aflac will provide benefits for the member to receive covered services at the office of an out-of-network general or specialist dentist at the same plan allowance as if they utilized a network provider.

The member may call ABS Member Services toll-free at 877-864-0625 for prior approval for in-network benefits at the non-participating provider. If a network adequacy issue is confirmed, the approval will be documented with a Single Case Agreement between ABS and the provider, and the claim will be adjusted to reflect in-network benefits post payment.

The claim will be adjusted to ensure the member's in-network benefit level is applied to all covered services. The member's portion of the coinsurance will be based off of the Maximum Allowable Charge (MAC) for the area to ensure the member's out of pocket costs will be no more than if they had been treated by a participating dentist.

ABS will provide oversight on the network management and will establish network expansion targets to ensure adequate appointment availability. ABS shall exercise contract termination provisions in extreme situations such as appointment discrimination or prolonged failure to comply with corrective action efforts.

Aflac retains oversight responsibility of all services delegated to ABS.

Referrals

Aflac members have the freedom of choice in selection of a provider. Members are not required to designate or choose a primary dental provider. Aflac does not require the member to contact Member Services for a referral in order to select or change a dentist.

Aflac utilizes the Network's general dentists who are licensed in the state to provide a comprehensive range of dental services. Network specialists are indicated when the procedures necessary for treatment are beyond the range of clinical skills of the Network general dentist and require the skills of a Network specialist. The Network has contracted with endodontists, periodontists, prosthodontists, oral surgeons, pediatric dentists, and orthodontists to provide necessary specialty services to members at negotiated fees.

Aflac does not require a referral to see a Network specialist. Dentists are not assigned and members are able to visit any general dentist or specialist without the need for a referral.

Comprehensive Listing of Participating Providers

Aflac ensures members have instant access to an updated list of participating Network general dentists and Network specialists in a variety of ways.

1. List of Participating Providers
   Every Aflac Group Dental member has access to view the online Provider Directory. To locate a provider, the member will select Provider Search located at https://www.aflacbenefitssolutions.com/. The member will select the Aflac Dental Plan from the drop down list, enter his/her City and/or Zip Code, and the distance, then click Search. The member can narrow the search results by selecting a Provider Specialty type, entering a provider's name or practice name, and select the gender. Additional search fields are available including language. The Provider Directory is updated daily.

   Any member of the public can access the online Provider Directory; it is available to non-members without a login required.

A request for a printed copy of the provider directory will be completed within five business days.

2. Member Services
   Members may contact Aflac Member Services toll-free at 855-819-1873 or ABS Member Services toll-free at 877-864-0625 to find a provider or to obtain further information on their Aflac Group Dental Benefits. Aflac Group Dental members who create credentials can also access their personal benefits and claims information through the secure member portal.

Ongoing Monitoring

Aflac and ABS have established extensive policies and procedures to ensure the dental care needs of the members are consistently and sufficiently met. One of the main focuses of the policies and procedures is to monitor the accessibility and availability of the provider network on a regular basis.

Using GEO-Access reporting through Quest Analytics, ABS measures, tracks, and trends network adequacy against the required access standards on a monthly basis in each county/state for each provider type. The reports compile information such as the number of members and their geographic distribution, distance to providers in their closest residential proximity, the percentage of providers accepting new patients, after-hours clinic availability and appointment standards, as well as the type of care (emergency, urgent care, or routine care).

Aflac's national standards with respect to member accessibility to participating providers are:

- Urban - provider within 30 miles from a member's residence
- Suburban - provider within 60 miles from a member's residence
- Rural - provider within 90 miles from a member's residence

This standard may be modified based on a state's regulation, if more stringent, or on state and local geographic conditions, such as dental specialists and member population in the area. The target of participating providers may be geographically distributed differently depending upon the density of population.

The above listed targets are statewide measures, considering rural, urban, and suburban areas. While these targets take into consideration less populated rural areas where a supply of providers is limited, Aflac may require the network to exceed these targets in urban areas. Aflac will require the Network to make reasonable efforts to contract with providers in extremely rural areas in any state as well as geographic areas with recognized maldistribution of dental specialists. Service areas are generally approved for an entire state.

Evaluation of performance indicators and diligent monitoring of network and enrollment changes assist ABS in identifying any hotspots where member need is high and network

concentrations are not in sync. This analysis is the foundation of an informed recruitment strategy, making sure that members have access to optimum high quality general and specialty dental care.

Provider Directory Audit

To maintain a high degree of data accuracy, the provider directory content is verified and updated on a regular basis. Our Provider Representative will contact providers quarterly via phone, email, or fax to verify their information in the provider directory is correct. Any necessary updates are sent to the Credentialing Department for system updates. Updates are completed within 24 hours to two business days of receiving updated information.

Members can report a discrepancy in the provider directory by calling ABS Member Services toll-free at 877-864-0625 or sending an email to Provider.relations@argusdentalvision.com.

Records of the provider directory audit are retained in compliance with Aflac's corporate record retention schedule.

Needs of Special Population

Aflac, through its affiliate ABS, has developed various services that are designed to address the special needs of members with limited English proficiency or literacy, diverse cultural and ethnic backgrounds, and with physical or mental disabilities.

ABS has implemented a Cultural Competency Plan to address issues of disparities and bias that can affect the quality of healthcare. Aflac and ABS are keenly aware that we provide services to a population that is continuously evolving into a highly diverse and multicultural population. Our goal is to provide services to members in a manner sensitive to the cultural background, religious beliefs, values and traditions. A copy of the Cultural Competency Plan is made available to our members and Network providers upon request and at no cost, and is shared via our public website https://www.aflacbenefitssolutions.com/. Scroll down to the bottom of the website and you will find it in the Legal & Miscellaneous section. Furthermore, ABS strives to provide all information in a culturally competent manner that assists all individuals in obtaining healthcare services. This includes those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, or physical-mental disability issues.

If a member requires special accommodations for his/her special needs, the member can contact ABS Member Services toll-free at 877-864-0625. The Member Services Representatives will work with ABS's Care Coordinators to facilitate the special request for the member.

Health Needs Assessment

Aflac's oral health risk assessment allows a member to identify his or her risk or protection factions that may influence oral health. A member can fill out this form from Aflac's website and take it to the member's next dental appointment. The health risk assessment can help the

general dentist see the member's risk level for oral disease, especially tooth decay.

Telehealth Services

Aflac's dental plan does not currently offer telehealth dental services; however, we will follow any state or federal emergency orders requiring them.

Communication with Members

Members are informed about their Aflac Group Dental Plan benefits through enrollment materials, the certificate of coverage, a public website, and a secure member portal. Aflac Group Dental members who create credentials can also access their personal benefits and claims information through the secure member portal.

Members may search our website https://www.aflacbenefitssolutions.com/ for a Network provider in their area at any time or they may contact us at our toll-free number 877-864-0625. Dentists are not assigned, and members are able to visit any general dentist or specialist without the need for a referral.

Members may seek care from any dentist and no prior authorization is required for obtaining emergency services. All general dentists are required to have 24-hour telephone access and schedule emergency appointments within 24 hours. Callers who contact Aflac or ABS for emergency care are instructed to seek assistance from any licensed dentist and if the member does not have a current dental provider, the Member Services Representative will assist the member in finding a provider.

If a member would like to file a complaint, grievance, or appeal with Aflac, the process to do so is on their Explanation of Benefits in the Important Information about Your Appeal Rights section. Members may also contact Aflac Member Services toll-free at 855-819-1873 or ABS Member Services toll-free at 877-864-0625 to obtain information about their appeal rights.

Coordination Activities

To ensure coordination for covered persons in the event of a provider's contract termination, the provider is obligated to cooperate and assist us in transferring members to another provider. We will notify these members no later than 30 days. Members may also contact Aflac Member Services toll-free at 855-819-1873 or ABS Member Services toll-free at 877-864-0625 to assist them in finding a new dental provider.

Continuity of Care

Provider Contract Termination

Aflac utilizes the networks leased through ABS from DenteMax, NovaNet, and Zelis for general dentists and specialists. Participating providers are contractually obligated to complete procedures in progress in the event of contract termination, for a period not to exceed 90 days.

Aflac will make a good faith effort to provide written notice of termination of discontinued providers within fifteen (15) business days, or otherwise as soon as practicable, to all members who are seen on a regular basis (within the past 12 months) by the provider or that receive primary dental services from the provider. Since dentists are not assigned to members, members are encouraged to check the status of a general dentist or specialist before receiving care.

With the exception of collecting copayments, deductibles, and amounts exceeding (a) benefit maximums or (b) for noncovered services as provided for in a member's benefit plan, participating providers will look only to the carrier/payor for compensation for covered services provided to a member. The participating provider will at no time seek compensation, remuneration, or reimbursement from members or persons acting on member's behalf, other than for allowable copayments, for covered services even if the carrier/payor for any reason, including insolvency, fails to pay the provider.

Plan for Insolvency or Other Inability to Continue Operations

Aflac is a well-established, national provider of life and health insurance products. In the unlikely event Aflac should ever become insolvent or otherwise be unable to continue operations, it would ensure members receive uninterrupted dental benefit coverage through the end of the applicable contract period. Aflac would ensure members receive advanced written notice of any anticipated change to Aflac's business operations.

Quality Assurance Standards

Aflac has established an extensive Quality Assurance Program to allow Aflac to identify, evaluate and remedy potential problems relating to access, continuity, and quality of care.

Aflac Group Dental products are supported by ABS's Quality Improvement Program ("Program"), which serves as the foundation of our organization's commitment to members, providers, regulatory agencies, and accrediting bodies and associates to continuously improve the quality of the treatment and services we provide. The Program links the activities of compliance, quality assurance, quality improvement, peer review, grievance and appeals, utilization management, and risk management into an organized, systematic, metric driven manner.

The Quality Management Work Plan ("Work Plan") continuously operates to improve the quality of the treatment and services we provide to our valued partners. The Work Plan acts in conjunction with the Program and is carried out with the help of various committees. The Work Plan includes a corporate listing of required meetings, schedule of the meetings, and quality monitoring statistics necessary to maintain an organized reporting and management system.

Our Quality Improvement Committee ("QIC") is established by charter and provides oversight of quality related activities of all departments. The QIC sets benchmarks for department quality standards and performance goals, assures that they are appropriately reported, and are

responsible for the integrity of the quality management and improvement program, the Utilization Management ("UM") program, the Health Education and Wellness Program ("HEW"), Provider Network appointment and reappointment process, policies and procedures, Member Satisfaction Survey reporting, Provider Satisfaction Survey reporting, and Clinical Guidelines.

ABS management's approach is to govern by committee and the Program follows basic principles of quality improvement with a team approach of clinical leaders, subject-matter experts, and day-to-day leadership to measure and monitor processes. As per the Work Plan, regularly scheduled quarterly committee meetings are held by leadership in HEW, Grievance & Appeals ("G&A"), UM, and Peer Review. High-level reporting of the metrics, discussions, and results in each meeting is then reported to the QIC no less than once each quarter.

The Governing Body, which includes the COO, is responsible for the oversight of all quality monitoring and improvement activities for ABS. This oversight is to include the approval of the Quality Management Work Plan, Quality Management Evaluation and Quality Improvement Program. In addition to oversight, the Governing Body provides guidance and strategic direction to all departments and committees. An annual evaluation of this is conducted and includes annual evaluation of process improvement projects and results, in addition to annual evaluation from leadership in the UM, G&A, and HEW Programs. All ABS Committees report up the Compliance Committee who in turn report up to the Governing Body.

Methods for Tracking and Assessing Clinical Outcomes from Network Services

Through Aflac's Utilization Management (UM) process, ABS monitors provider over- and under-utilization and works directly with the providers when it is identified that a provider may have an opportunity to increase the occurrence of preventive care, reduce the use of emergency dental treatment where a higher level of care may possibly be avoided by education from the dental provider, and more aggressive attempts to engage the member in good oral hygiene and routine care. The UM Reviewers submit cases to the Dental Director when they identify treatment plans or a course of treatment where the service requires confirmation of medical necessity or where an alternate treatment may be available for positive healthcare outcomes.

Aflac's UM Department has established a comprehensive program to track and trend UM processes, which allow us to better evaluate and design our benefit structure and UM processes to assure continuity of care is provided to members. By monitoring utilization data, trends can be identified which can demonstrate rapid or unusual changes or patterns of treatment that may positively or negatively affect members. Dental utilization is tracked on a continual basis with hands-on involvement of the Dental Director.

Established methodologies are used for measurement purposes to every extent possible. When UM concerns are identified, an action plan is established by the QIC. Such action plans may

include provider education, member education, staff development, administrative changes, provider contract changes and/or alteration of provider privileges. The scope of each action plan is determined based on the circumstances and identified causes that relate to each unique adverse outcome or variance from the standard.

The scope of each action plan is approved by the QIC, which ensures that interventions are timely and meaningful. Re-measurement is performed at appropriate intervals to determine the effectiveness of interventions.

Aflac and ABS periodically review utilization within and across defined groups to determine trends, patterns, and aberrancy of utilization with the objective of early detection of member/provider trends. Comparisons are made against benchmarks, historic norms, and acceptable methodologies for measurement. The UM reviewers submit cases to the Dental Director when they identify treatment plans or a course of treatment where the service requires confirmation of medical necessity or where an alternate treatment may be available for positive healthcare outcomes.

Tracking utilization gives Aflac and ABS the ability to communicate with providers as to treatment trends performed in the provider's office, the frequency and types of services rendered, as well as overall production. This offers an open exchange of utilization trends to aid the provider's office in rendering timely and appropriate dental care to members. Long-term trends can indicate a provider's increase of efficiency as well as effectiveness of care.

Methods for Evaluating Consumer Satisfaction with Services Provided

Aflac and ABS monitor member satisfaction through the analysis of member complaints, grievances and appeals. Aflac and ABS have a Grievance Committee, which is overseen by the Quality Improvement Department. The Grievance Committee is responsible for the processes for identifying, reporting, and resolving reported grievances, complaints, and appeals from members. The Grievance Committee strives to ensure that reported matters are handled in an efficient and timely manner. In addition, the Grievance Committee is responsible for the facilitation of reporting to the QIC. This is to ensure the implementation of an effective resolution process and adherence to all regulations and contract requirements. On a quarterly basis, the Grievance Committee analyzes, tracks, and trends all complaints, grievances, and appeals and works with the QIC to rectify any company or provider issues that appear to be trending.

Recommendations may be made to management related to benefits or administrative issues, or to providers or the Networks if the trends are related to provider offices, services rendered by providers, or network access issues. The Grievance Committee may institute and monitor Corrective Action Plans.

Additionally, the Quality Department conducts member satisfaction surveys each month. Survey results are analyzed and reported to the QIC. The QIC is responsible for the integrity of the quality management and improvement program, including the Member Satisfaction Survey reporting.