Aflac Dental Insurance

PPO PLAN 2

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

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.

Issued by:
American Family Life Assurance Company of New York
22 Corporate Woods Boulevard, Suite 2 | Albany, New York 12211

AFLAC DENTAL INSURANCE - PPO

Policy NYQN81100M

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Aflac gives you something to smile about

Dental health is about more than a beautiful smile. Good oral care might actually improve your overall health, while problems with oral care might have a negative effect.

Dental care is important, but it can also be expensive – even cleaning and x-rays can sometimes strain your budget. If a checkup reveals more serious issues, the cost can quickly become overwhelming. Dental coverage from Aflac helps give you the peace of mind that comes from knowing you'll have assistance with both routine and unexpected dental expenses.

Why choose Aflac dental insurance?

With Aflac, you can select from an expansive list of participating providers, or you may choose a non-participating provider. Consider, however, that out-of-network costs (if any) will generally be more than if treatment is performed by a participating provider. Services provided out of network will be paid based on the price of usual, customary and reasonable services in the area in which they are rendered.

Plan highlights

- Deductible that decreases over time
- No waiting period for any services
- Dental implants covered

Deductible

- Year 1: $50/person (three per family)
- Year 2+: No deductible

We make it easy to find a provider! You can visit www.aflac.com/DentalNetwork and click "Provider Search" or call Aflac directly at **1.877.864.0625.**

When making a dental appointment, please identify yourself as an Aflac New York Dental PPO member and present your ID card at each visit.

Aflac herein means American Family Life Assurance Company of New York.

WHAT IS COVERED?

Services	In-Network and Out-of-Network Benefit	
	WE PAY	**YOU PAY**
PREVENTIVE AND DIAGNOSTIC SERVICES • Routine exams and cleanings (two per year; two additional cleanings when recommended by a medical doctor due to an underlying medical condition) • Bitewing x-rays (one per 12 months) • Full-mouth x-rays (one every 36 months) • Sealants (for children under age 16; one per tooth per 36 months) • Fluoride treatments (for children under age 19; one per 12 months) • Space maintainers	100% (deductible waived)	0%
BASIC SERVICES • Fillings (amalgam and composite) • Emergency palliative treatment • Simple and surgical extractions • Crown, bridge and denture repair	80%	20%
MAJOR SERVICES • Inlays, onlays, crowns, bridges and dentures • Nonsurgical and surgical periodontics • Endodontics • Oral surgery • Anesthesia • Implants	50%	50%

WAITING PERIODS	None
DEDUCTIBLE • Waived for preventive • No deductible starting in year two	Year 1: $50/person (three per family) Year 2+: No deductible
ANNUAL MAX	$1,500

If you have dental coverage under more than one plan, your benefits may be coordinated. Please see certificate for details.
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 brochure 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.

TERMS YOU NEED TO KNOW

Allowed amount: the maximum amount we will pay for the services or supplies covered under the certificate, before any applicable copayment, deductible and coinsurance amounts are subtracted. The allowed amount for participating providers will be the amount we have negotiated with the participating provider, or the participating provider's charge, if less. Unless the policyholder has selected an in-network only plan, the allowed amount for non-participating providers is based on the type of maximum reimbursement in the plan that is issued and will be the lesser of (a) the provider's charge or (b) a rate based on information provided by a third party vendor, which may reflect one or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable providers' fees and costs to deliver care. If your non-participating provider charges more than the allowed amount, you will have to pay the difference between the allowed amount and the provider's charge, in addition to any cost-sharing requirements.

Covered services: the medically necessary services paid for, arranged, or authorized for you by us under the terms and conditions of the certificate.

Deductible: the amount you owe before we begin to pay for covered services. The deductible applies before any copayments or coinsurance are applied. The deductible may not apply to all covered services. You may also have a deductible that applies to a specific covered service that you owe before we begin to pay for a particular covered service.

Dependents: the subscriber's spouse and children. Spouse is the person to whom the subscriber is legally married, including a same sex spouse. Spouse coverage also includes domestic partners, subject to proof of the domestic partnership. Children include your or your spouse's natural children, legally adopted children, step children, and children for whom you are the proposed adoptive parent without regard to financial dependence, residency with you, student status or employment. Coverage lasts until the day the child turns 26.

Refer to your certificate for details.

Emergency dental care: emergency dental treatment required to alleviate pain and suffering caused by dental disease or trauma.

In-network benefits: the highest level of coverage available. In-network benefits apply when a member's care is provided by participating providers in our network. Members should always consider receiving dental care services first through the in-network benefits portion of the plan.

Non-participating provider: a provider who doesn't have a contract with us to provide health care services to you. You will pay more to see a non-participating provider.

Out-of-network benefits: the out-of-network benefits portion of the plan that provides coverage when a member receives covered services from non-participating providers. A member's out-of-pocket expenses will be higher when out-of-network benefits are received. In addition to cost-sharing, a member will also be responsible for paying any difference between the allowed amount and the non-participating provider's charge. See the Schedule of Benefits and Schedule of Covered Procedures sections of the certificate for more information.

Participating provider: a provider who has a contract with us to provide health care services to you. A list of participating providers and their locations is available on our website [at Aflac.com/dentalnetwork] or upon your request to us. The list will be revised from time to time by us.

ADDITIONAL INFORMATION

WHEN COVERAGE BEGINS

Coverage under the certificate will begin as follows, if you, the subscriber:

- elect coverage before becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, coverage begins on the date you become eligible, or on the date determined by your group.
- do not elect coverage upon becoming eligible or within 30 days of becoming eligible for other than a special enrollment period, you must wait until the group's next open enrollment period to enroll, except as provided below.
- marry while covered, and we receive notice of such marriage and premium payment within 30 days thereafter, coverage for your spouse and child starts on the first day of the following month after the date of the marriage. If we do not receive notice within 30 days of the marriage, you must wait until the group's next open enrollment period to add your spouse or child.
- have a newborn or adopted newborn child and we receive notice of such birth within 30 days thereafter, coverage for your newborn starts at the moment of birth; otherwise, coverage begins on the date on which we receive notice. Your adopted newborn child will be covered from the moment of birth if you take physical custody of the infant as soon as the infant is released from the hospital after birth and you file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 30 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. If you have subscriber or subscriber and spouse coverage, you must also notify us of your desire to switch to parent and child/children or family coverage and pay any additional premium within 30 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which we receive notice, provided that you pay any additional premium when due.

Other stipulations may apply. See your certificate for details.

TERMINATION OF COVERAGE

Coverage under the certificate will automatically be terminated on the first of the following to apply:

- The group and/or subscriber has failed to pay premiums within 30 days of when premiums are due. Coverage will terminate as of the last day for which premiums were paid.
- The date on which the subscriber ceases to meet the eligibility requirements as defined by the group.
- Upon the subscriber's death, coverage will terminate unless the subscriber has coverage for dependents. If the subscriber has coverage for dependents, then coverage will terminate as of the last day of the month for which the premium has been paid.
- For spouses in cases of divorce, the date of the divorce.
- For children, until the day the child turns 26 years of age.
- The end of the month during which the group or subscriber provides written notice to us requesting termination of coverage, or on such later date requested for such termination by the notice.
- If the subscriber has performed an act that constitutes fraud or made a misrepresentation of material fact in writing on his/her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by us to the subscriber. However, if the subscriber makes a misrepresentation of material fact in writing on his or her enrollment application we will rescind coverage if the facts misrepresented would have led us to refuse to issue the coverage. Rescission means that the termination of your coverage will have a retroactive effect of up to your enrollment under the certificate. If termination is a result of the subscriber's action, coverage will terminate for the subscriber and any dependents. If termination is a result of the dependent's action, coverage will terminate for the dependent.
- The date that the group policy is terminated. If we decide to stop offering a particular class of group policies, without regard to claims experience or health related status, to which the certificate belongs, we will provide the group and subscribers at least 30 days' prior written notice.
- The group has performed an act or practice that constitutes fraud or made a misrepresentation of material fact under the terms of the coverage.
- The group has failed to comply with a material plan provision relating to group participation rules. We will provide written notice to the group at least 30 days prior to when the coverage will cease.
- The group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage. We will provide written notice to the group and subscribers at least 30 days prior to when the coverage will cease.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

See the Continuation of Coverage section of the certificate for your right to continuation of the coverage under COBRA or USERRA.

Other stipulations may apply. See your certificate for details.

LIMITATIONS AND EXCLUSIONS

No coverage is available under the certificate for the following:

Cosmetic Services.
We do not cover cosmetic services or surgery unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered child which has resulted in a functional defect. Cosmetic surgery does not include surgery determined to be medically necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of the certificate unless medical information is submitted.

Coverage Outside of the United States, Canada or Mexico.
We do not cover care or treatment provided outside of the United States, its possessions, Canada or Mexico, except for emergency dental care.

Experimental or Investigational Treatment.
We do not cover any health care service, procedure, treatment, or device that is experimental or investigational. However, we will cover experimental or investigational treatments, including treatment for your rare disease or patient costs for your participation in a clinical trial, when our denial of services is overturned by an external appeal agent certified by the state. However, for clinical trials, we will not cover the costs of any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be covered under the certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of the certificate for a further explanation of your appeal rights.

Felony Participation.
We do not cover any illness, treatment or medical condition due to your participation in a felony, riot or insurrection.

Medical Services.
We do not cover medical services or dental services that are medical in nature, including any hospital charges or prescription drug charges.

Medicare or Other Governmental Program.
We do not cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

Military Service.
We do not cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

No-Fault Automobile Insurance.
We do not cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under a mandatory no-fault policy.

Services Not Listed.
We do not cover services that are not listed in the certificate's Schedule of Covered Procedures as being covered.

Services Provided by a Family Member.
We do not cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of you or your spouse.

Services Separately Billed by Hospital Employees.
We do not cover services rendered and separately billed by employees of hospitals, laboratories or other institutions.

Services with No Charge.
We do not cover services for which no charge is normally made.

War.
We do not cover an illness, treatment or medical condition due to war, declared or undeclared.

Workers' Compensation.
We do not cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.


Aflac

aflac.com | 1.877.864.0625

Applies to Policy NYQN81100M.

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