Aflac Dental Insurance

MAC PLAN 3

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.

NOTICE: The plan does not contain comprehensive adult wellness benefits as defined by Wyoming law.

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

Aflac®

AFLAC DENTAL INSURANCE - MAC

Policy Series QN81000

DE M3

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 up to the maximum allowable charge, which is set based on the price of customary charges from the area in which the services are rendered as provided in the terms of the employer policy.

Plan highlights

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

Deductible

- Year 1: $50/person (three per family)
- Year 2: $25/person (three per family)
- Year 3+: 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 Dental PPO member and present your ID card at each visit.

Aflac herein means American Family Life Assurance Company of Columbus.

WHAT IS COVERED?

Services	In-Network and Out-of-Network Benefit
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)
BASIC SERVICES • Fillings (amalgam and composite) • Emergency palliative treatment • Simple and surgical extractions • Crown, bridge and denture repair • Nonsurgical and surgical periodontics • Endodontics	90%
MAJOR SERVICES • Inlays, onlays, crowns, bridges and dentures • Oral surgery • Anesthesia • Implants	50%
WAITING PERIODS	None
DEDUCTIBLE • Waived for preventive • No deductible starting in year three	Year 1: $50/person (three per family) Year 2: $25/person (three per family) Year 3+: No deductible
ANNUAL MAX	$2,000
DENTAL ACCIDENTAL INJURY BENEFIT	Coinsurance increased to 100% for covered dental injuries.
MAXIMUM CARRYOVER BENEFIT Members may build up an additional $1,000 towards their 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: 1. An insured submits at least one qualifying claim for Class A dental expenses incurred during the calendar year, and/or 2. At least one qualifying claim for any other Class dental expense in excess of applicable deductible or co-pay fees, and 3. The total benefit amount paid stays below $500 for that calendar year.

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.

In Arkansas, the following in-network and out-of-network requirements apply: The payment difference between the reimbursement for in-network providers and out-of-network providers will not exceed 10%. The insured person's cost-sharing amount may differ for in-network services versus out-of-network services, but by no more than 25%, taking into consideration all cost-sharing arrangements.

In South Carolina, medically necessary orthodontics or dental care for an insured dependent child as a result of cleft lip and/or cleft palate will be covered to the same extent and subject to the same terms and provisions as other conditions or procedures covered by the plan.

TERMS YOU NEED TO KNOW

Covered dental injury: an injury to a sound natural tooth, sustained while the insured person is insured under the plan, and which is caused solely by a sudden violent act (in Utah, a sudden act) or accident which could not be predicted in advance or avoided.

Covered procedure: means the procedures listed in the Schedule of Covered Procedures. The procedure must be: (1) for necessary dental treatments to an insured person while their coverage under the plan is in force and (2) for treatment, which in our opinion has a reasonably favorable prognosis for the patient. (In Texas, (2) for treatment, which has a reasonably favorable prognosis for the patient.) The procedure must be performed by a:

- licensed dentist who is acting within the scope of his license; or
- licensed dental hygienist acting under the supervision and direction of a dentist, if required.

Deductible: the deductible is the amount of the maximum reimbursement which must be paid in full by you each plan year (or lifetime, when applicable) for each insured person (or to the maximum per family limit, when applicable) who incurs a covered procedure before any benefits are payable. The deductible is applied chronologically according to the dates on which the covered procedures on a claim were completed. The amount of the deductible is shown in the deductible section of the Schedule of Benefits.

Eligible dependent: someone who is residing in the United States and who is:

- your legally married spouse or partner in a legally recognized union; or
- your or your spouse's natural child, stepchild, legally adopted child, child in your custodial care pursuant to a court order, or child for whom you have been appointed as legal guardian, who is under age 26.

Other stipulations may apply. See your certificate for details. The definition of spouse and children vary by state.

Functioning natural tooth: a natural tooth which is performing its normal role in the mastication (i.e., chewing) process in the insured person's upper or lower arch and which is opposed in the person's other arch by another natural tooth or prosthetic (i.e., artificial) replacement. Third molars are not considered functioning natural teeth for purposes of the plan.

In-network benefits: dental benefits provided under the certificate for covered procedures that are provided by a participating provider. We recommend that you verify the provider's participation status in the network.

Maximum allowable charge (mac): When a participating provider performs a covered procedure, the mac is determined to be the lesser of: (a) the actual dental charge (In North Dakota, the dental charge); or (b) the amount that the dentist has agreed with us to accept as payment in full for a dental service. Unless the policyholder has selected an in-network only plan, (In Arkansas, Georgia, North Dakota, South Dakota, and Texas, in-network only plan does not apply), when a non-participating provider performs a covered procedure, the mac is determined to be the lesser of: (a) the actual dental charge (In North Dakota, the dental charge); or (b) a percentile of the "customary charge" for the dental service. We determine the percentile of the "customary charge" from within the range of charges made for the same service by other providers of similar training or experience in that general geographic area.

Non-participating provider: a dentist who is not a participating provider. These dentists have not entered into an agreement with us to limit their charges.

Out-of-network benefits: dental benefits provided under the certificate for covered procedures that are not provided by a participating provider. An in-network only plan does not provide these benefits, except for emergency treatment with a covered procedure or a covered procedure performed in a limited access area. (In Alaska, Arkansas, Georgia, North Dakota, South Dakota, and Texas, the in-network only statement is not applicable.)

Participating provider: a dentist who has been selected by the administrator for inclusion in the participating provider program. These participating providers agree to accept the participating provider maximum allowed charges as payment in full for services rendered. (In Louisiana, we will not discriminate against any provider located within the geographic coverage area who is willing to meet the terms and conditions for participation established by us.) When dental care is given by participating providers, the insured person will generally incur less out-of-pocket cost for services rendered.

TERMS YOU NEED TO KNOW

EFFECTIVE DATE PROVISIONS

Eligible members and eligible dependents
Coverage takes effect on the certificate effective date shown on your ID card.

Additional dependents
The effective date of any newly acquired eligible dependent will be governed by the same rules as described above under the heading "eligible members and eligible dependents." You must first complete, sign and submit to us a new enrollment form for all your additional dependents, including newborn children, and submit the additional premium, if any. However, newborn children will be covered for the first 90 days following their birth. To continue coverage beyond that 90-day period, you must notify us in writing of the child's date of birth at any time during the 90-day period.

Other stipulations may apply. See your certificate for details. The definition of spouse and children vary by state.

TERMINATION PROVISIONS

Insured members
All of your insurance under the policy will terminate at 11:59 p.m. at the main office of the policyholder on the earliest of the following dates:

- The date the policy terminates (in Pennsylvania, the date the policy terminates after the initial term);
- The last day of the month in which you cease to be an eligible member;
- The date you die; or
- On any premium due date, when full payment for insurance is not made within the grace period.

If an event that is described above occurs, written notice must be provided to us, by you or the policyholder, within 31 days of such event. (In Connecticut, if the policy terminates for any reason other than nonpayment of premium, the policyholder must notify you at least 15 days prior to the termination date unless similar coverage becomes effective immediately upon termination with no interruption in coverage.)

Insured dependents
Your dependent's insurance under the policy will terminate at 11:59 p.m. at the main office of the policyholder on the earliest of the following dates:

- The date the policy terminates;
- The last day of the month in which you cease to be an eligible member;
- The date the insured dependent ceases to be an eligible dependent;
  - In Utah, the last day of the month in which the insured dependent ceases to be an eligible dependent;
- The date you die;
- The date the insured dependent dies;
- On any premium due date, when full payment for insurance is not made within the grace period; or
- The date we receive your request to terminate dependent coverage subject to any limitation imposed by the policyholder.

If an event that is described above occurs, written notice must be provided to us, by you or the policyholder, within 31 days of such event.

Notice required when your coverage terminates
We must be informed promptly, by you or the policyholder, when your status as an eligible member terminates for any reason. Failure to provide timely notice will not continue your insurance past the time it would have otherwise ended as provided above.

In the event premiums have been paid to us on your behalf after your coverage should have terminated, we will refund the premium for the period for which premiums were paid in error up to a maximum of three policy months or to the last policy anniversary, whichever is less. If we are not notified that your coverage is terminated and we pay any benefits for your covered procedures incurred after the date your coverage terminated, the full amount of those benefits will be considered an overpayment which must be repaid to us.

Other stipulations may apply. See your certificate for details.

LIMITATIONS AND EXCLUSIONS

State references within this brochure refer to the state of your group and not your resident state.

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; (In Alaska and Michigan, "as determined by us" does not apply.)
  - In Texas, also, any procedure we determine is not necessary, does not offer a favorable prognosis, does not have uniform professional endorsement or is experimental in nature; 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; or dental treatment not approved by the American Dental Association or which is clearly experimental in nature;
- Any procedure we determine is not necessary (In Michigan, any procedure determined not necessary), does not offer a favorable prognosis, does not have uniform professional endorsement or is experimental in nature;
  - In Alaska, this exclusion does not apply.
- 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;
  - In Texas, also, or dental treatment not approved by the American Dental Association or which is clearly experimental in nature;
- 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 (In Georgia, procedure must be medically necessary);
- 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 (In D.C., act of terrorism; In Alaska, "terrorism" does not apply) or taking part in (In Utah, voluntarily taking part in) an insurrection or riot; the commission (In Utah, the voluntary commission) or attempted commission of a crime (In D.C., Indiana and South Dakota, a felony); an intentionally self-inflicted injury or attempted suicide while sane or insane;
  - In Michigan, dental disease, defect or injury caused by a declared or undeclared war or any act of war or terrorism; the commission of or attempt to commit a felony or to which a contributing cause was the insured person's being engaged in an illegal occupation or other willful criminal activity;
  - In Oklahoma, any act of war while serving in the military or an auxiliary unit thereto;
- Dental treatment not approved by the American Dental Association or which is clearly experimental in nature;

LIMITATIONS AND EXCLUSIONS

- 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;
  - In Utah, also any charge for a service performed outside of the United States other than for emergency treatment;
- Any charge for a service performed outside of the United States (in Alaska, also Canada) other than for emergency treatment. Benefits for emergency treatment performed outside of the United States (in Alaska, also Canada) are limited to a maximum of $100 per year;
  - In Utah, this is not applicable.
- 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;
  - In Texas, this exclusion does not apply;
  - In South Dakota, a member of the insured person's family may perform services if the family member is the only dentist in the area and provided the dentist is acting within the scope of practice;
- 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.
  - In Alaska, Arkansas, Georgia, North Dakota, South Dakota and Texas, this exclusion is not applicable.

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Applies to Policy Series QN81000. In Arkansas, policy form QN81100MAR. In Oklahoma, policy form QN81100MOK. In Oregon, policy form QN81100MOR and QN81100MORS. In Pennsylvania, policy form QN81100MPA. In Texas, policy form QN81100MTX.

Coverage is underwritten by Aflac. WWHQ | 1932 Wynnton Road | Columbus, GA 31999