

GROUP PPO DENTAL INSURANCE
Wear a smile — it goes with everything



EMPLOYEE
BROCHURE



Ryan's Story¹

Ryan saw a dentist twice a year, without fail, while he was growing up. But once he was on his own, he got out of the habit because of the costs. When his employer began offering a group PPO dental insurance plan, Ryan signed up right away. Two weeks later, a bicycling accident knocked out two of his front teeth. Fortunately, the plan helped Ryan pay for the treatments that restored his smile. And, because the charges were accident-related, his deductible was waived.

Why Dental Insurance?

The key to keeping your teeth and gums healthy is maintenance, which includes regular checkups and any needed services, including unforeseen treatments — but unexpected dental costs can often be overwhelming. Dental insurance can help you manage these costs.

Did You Know?

According to a national health survey, adults ages 20 to 64 have an average of 3.28 decayed or missing permanent teeth.

National Institute of Dental and Craniofacial Research, March 2009.

How Does the PPO Plan Work?

With a PPO plan, you have access to a huge network of dentists through the SmileMaxSM national dental network.² The network's thousands of dental professionals have contracted to provide dental service at negotiated fees, which can significantly lower your out-of-pocket expense. If you choose a network dentist, you'll be charged only negotiated fees that are guaranteed to be at or under the Maximum Allowable Charge (MAC).³

You can also choose a dentist outside the network and receive out-of-network benefits. If you visit an out-of-network dentist, the amount you'll have to pay depends on your plan:

- For MAC plans, you'll be charged the dentist's usual charge and your coinsurance is applied to the MAC. You'll be responsible for the difference, which can result in increased out-of-pocket expense.
- For Reasonable and Customary (R&C) plans, you'll be charged the dentist's usual charge and your coinsurance is applied to the R&C charge. An "R&C charge" is an amount that is not more than the dentist's usual charge for the services and not more than the usual charges made by most other local dentists with similar training and experience. After you pay the deductible, the plan will pay a percentage of the dentist's charge, up to the R&C limits. You then pay the balance (if any) of the dentist's fees.

Here's a procedure example: One root canal covered under Basic services (ADA Code 3310).

In-Network Dentist		MAC Plan Out-of-Network Dentist		R&C Plan Out-of-Network Dentist	
MAC	\$400 ⁴	Dentist's usual charge	\$500 ⁴	Dentist's usual charge	\$500 ⁴
Plan will pay 80% of MAC	\$320 ⁵	Plan will pay 80% of MAC	\$320 ⁵	Plan will pay 80% of R&C (\$500)	\$400 ⁵
Insured pays only	\$80	Insured pays only	\$180	Insured pays only	\$100

Clearly, the out-of-pocket savings can be substantial with in-network dentists.

¹ Not an actual case; presented for illustrative purposes only.

² The dental network is powered by Careington International and DenteMax. In Nevada, the dental network is powered by Diversified Dental Services, Inc. Availability may vary by state.

³ Maximum amount that a participating provider will charge and the maximum amount that American General will consider a covered charge.

⁴ For illustration purposes only. Fees will vary by geographic location.

⁵ Assumes plan deductible has been met. After deductible is met, plan pays 80 percent in-network, 80 percent MAC out-of-network or 80 percent R&C out-of-network.

What Can This PPO Plan Offer Me?

Choice

- Access to the SmileMax dental network — with more than 132,000 provider locations nationwide.
- Choice of providers, in- or out-of-network, without restriction.
- Coverage for a wide range of valuable services.

Savings

- Deductible will be waived for any dental charges due to a non-job-related accident.
- Network dentists have contracted to provide services at negotiated fees to keep your out-of-pocket costs lower.
- Network discounts apply even after the annual maximum has been exhausted.
- Network discounts apply for services not covered under the dental insurance policy.

Convenience

- Quick and easy enrollment.
- Premiums paid through payroll deductions.
- Online provider search feature at www.americangeneral.com/employeebenefits.

Plan Details

Eligibility

Employees actively at work 30 or more hours a week are eligible (amount of hours may vary by state).

Eligible dependents include your spouse and any children under the age of 19. Children older than 19 years of

age are eligible if they are dependent, full-time students under the age of 25. Coverage for insured dependent children begins at age three (if the application is made within 31 days after the child's third birthday, no late entrant requirements will apply).

Late Entrants

Employees who elect coverage more than 31 days after they first become eligible, or elect coverage again after their insurance ended due to nonpayment of premiums, are considered late entrants. Once a late entrant elects coverage, the plan will pay for covered services after the following waiting periods:

- Preventive services — no waiting period
- Fillings — after six months
- Other Basic services — after 12 months
- Major services — after 24 months
- Orthodontic services (if applicable) — after 24 months

Employees or their dependents who waived coverage because they had coverage elsewhere will be able to enroll at any time, without late entrant penalties, if prior coverage has terminated — provided the person enrolls within 31 days of loss of other coverage. Proof of prior coverage is required with the enrollment form.⁶ (Note: Time period may vary by state.)

See Benefit Summary for additional information.

Enroll Today!

Enroll in the PPO plan today. Your premium will be conveniently taken through payroll deduction.

About American General Life Companies (American General⁷)

Just as your family turns to you for security and peace of mind, millions of Americans turn to American General for help protecting their families against financial hardship.

- American General's companies are collectively the top issuers of insurance by face amount in the U.S. and an industry leader in its core businesses.
- American General's companies are closely regulated by state insurance departments, with ample reserves and capital to meet the long-term obligations to policyholders.
- American General's companies have more than 11.6 million policies in force, as of 12/31/07.⁸
- American General stands ready to pay claims, making on average \$24 million in claim payments every single business day.⁹
- Over the past five years, American General's companies have paid out \$17.5 billion in benefits to 1.6 million families and businesses.¹⁰
- The general account of each insurer is primarily invested in high-quality, investment-grade bonds, in accordance with state insurance requirements and investment guidelines.
- The most prominent independent ratings agencies continue to recognize American General insurers in terms of insurer financial strength. For detailed information on specific insurer ratings, visit www.americangeneral.com/ratings.

⁶ For employee-paid plans, if an employee voluntarily terminates coverage, he or she may rejoin the plan by requesting coverage after at least 12 months outside the plan. The person will be added at the next annual enrollment and will be subject to the late entrant waiting periods. For employer-funded plans, if an employee voluntarily terminates coverage, he or she may rejoin the plan provided he or she had been out of the plan for at least 12 months. Then late entrant waiting periods or penalties will apply.

⁷ Information regarding American General is for informational purposes only.

⁸ Source: Statutory Annual Statements for the Domestic Life Companies, 2007.

⁹ Source: Statutory Annual Statements for the Domestic Life Companies, as of June 30, 2008.

¹⁰ Source: Statutory Annual Statements for the Domestic Life Companies, 2003 – 2007.

Limitation of Benefits (state variations may apply)

- If two or more procedures are adequate and appropriate treatment for a certain condition, the least costly will be used to determine benefits.
- If a tooth is lost or extracted prior to coverage under this policy, a prosthetic device to replace such tooth will not be covered, unless the device also replaces at least one other tooth lost or extracted while the insured is covered under this policy.
- Charges must be incurred while insured to be eligible. The incurred date of the charges is the date on which the service is performed, except for:
 - Crowns, bridges and cast restorations, which is the date the tooth is prepared.
 - Other prosthetic devices, which is the date the master impression is taken.
 - Root canal therapy, which is the date the pulp chamber is opened.

Charges Not Covered (state variations may apply)

- Services not specifically listed in the Schedule of Covered Dental Services.
 - Sealants, if reduced premium option is selected.
 - Oral hygiene, plaque control, diet instruction.
 - Precision attachments.
 - Treatment that does not meet accepted standards of dental practice.
 - Treatment that is experimental in nature.
 - Treatment that is due to an on-the-job related injury; or a condition for which benefits are payable under Workers' Compensation or similar laws.
 - Orthodontic treatment, unless the Schedule of Covered Dental Services lists orthodontia benefits.
 - Orthodontic class 1 malocclusions.
 - Appliance or prosthetic device used to change vertical dimension.
 - Appliance or prosthetic device used to restore or maintain occlusion, except to the extent that orthodontic benefits are covered.
- Appliance or prosthetic device used to splint or stabilize teeth for periodontic reasons.
 - Appliance or prosthetic device used to replace tooth structure lost as a result of abrasion or attrition.
 - Appliance or prosthetic device used to treat disturbances of the temporomandibular joint (TMJ), except to the extent that supplemental bundled benefits, including TMJ services are covered.
 - Cosmetic services, including but not limited to:
 - Bleaching (except to the extent that supplemental bundled benefits, including bleaching, are covered).
 - Making facings on prosthetic devices for any tooth posterior to the second bicuspid.
 - Characterizing and personalizing prosthetic devices.
 - Replacement of an appliance or prosthetic device unless:
 - The appliance or device is at least 10 years old and cannot be made usable.
 - The appliance or device is damaged while in the insured person's mouth in an injury that occurs while insured, and it cannot be repaired.
 - Replacement crowns within 5 years of initial placement.
 - Replacement of a lost, stolen or missing appliance or prosthetic device.
 - Making a spare appliance or device.
 - Services or devices for which no charge is made, including but not limited to services provided by:
 - The covered person's employer, labor union or similar group, in its dental or medical department or clinic.
 - A facility owned or run by any government body.
 - Any public program except Medicaid, paid for or sponsored by any government body.
 - For surgery, periodontic and endodontic treatment, separate payment will not be made for X-rays, local anesthetics, treatment plan or follow-up care. These are all included in payment for the procedure.

- Charges for IV sedation and other analgesics, excepting general anesthesia.
- Diagnostic casts, models and study models.
- Implants and all related services, except to the extent that supplemental bundled benefits including implants are covered; then, only limited implant procedures as set forth in the Schedule of Covered Dental Services are covered.
- Radical resection of mandible with bone graft.
- Interim crowns and dentures.
- Treatment given after insurance ends, regardless of when the injury or sickness occurred.
- Procedures and services that are not essential for the necessary care and treatment of the dental condition.
- Treatment that would be given free of charge if the person were not insured.
- Any expense that results from a war or act of war.
- Any expense incurred while the insured person is on active duty or training in the armed forces, National Guards or reserves of any state or country, and for which any governmental body or its agencies are liable.
- Any expense resulting from an intentionally self-inflicted injury.
- Treatment given by a person's immediate family member.
- Treatment given by a person's employer or an employee of such employer.
- Any expense for services or supplies which are provided or paid for by the federal government or its agencies for:
 - The Veterans Administration, when services are provided to a veteran for a disability which is not service-connected.
 - A military hospital or facility, when services are provided to a retiree (or dependent of a retiree) from the armed services.
 - A group plan established by government for its own civilian employees and their dependents, or Medicaid, if required by Medicaid assignment of benefits.

Policies issued by:

American General Life Insurance Company of Delaware

Wilmington, Delaware

Policy Form Number G-DEN-42000

American International Life Assurance Company of New York

New York, New York

Policy Form Number G-DEN-32000

www.americangeneral.com/employeebenefits

American General Life Companies, www.americangeneral.com, is the marketing name for the insurance companies and affiliates comprising the domestic life operations of American International Group, Inc., including American General Life Insurance Company of Delaware and American International Life Assurance Company of New York.

American General Life Companies insurers offer a broad spectrum of life insurance, fixed annuities, accident and health products and worksite benefits to serve the financial and estate planning needs of customers throughout the United States.

The underwriting risks, financial and contractual obligations and support functions associated with products issued by American General Life Insurance Company of Delaware and American International Life Assurance Company of New York are each insurer's own responsibility. American International Life Assurance Company of New York is authorized to do an insurance business in New York. Policies are not available in all states.

This is a summary only of products and services offered. Actual offerings may vary by group size and are subject to state insurance law, and the benefits/provisions as described may vary due to such law. All products are subject to the terms, conditions, limitations and exclusions of the policy. Please see policy and certificate for details.

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