



## A Major Medical Program for Members of the Texas Dental Association



**Endorsed by TDA Financial Services, Inc. (FSI)**

An affiliate of the Texas Dental Association



**Underwritten by: New York Life Insurance Company**



# A Major Medical Insurance Plan For Members Of The Texas Dental Association

## The Plan That Can Deliver Superior Health Coverage Value

The need for quality broad-benefit health coverage is more crucial than ever before. Without it, the cost of treating a serious illness or injury could devastate your financial security...

But, as we all know, the kind of quality coverage we'd like to have can be prohibitively expensive. That's why, as a TDA Member, you can enjoy the advantages of TDA's group purchasing power. This Plan is designed to suit your needs, life-style, and financial capabilities.

Thanks to your group's priority concern for the protection needs of Members and their families, you can get quality broad - benefit health coverage with **this sponsored Major Medical Insurance Plan**. It is an affordable choice in major medical coverage - it can help you meet your health insurance needs in the 21st century.

The Plan is underwritten by New York Life Insurance Company, one of the largest and most respected life insurance companies in the nation.

## Freedom To Choose In or Out-of-Network Health Care Providers

Confronting a health condition can be stressful enough without the added worry of being treated by a doctor you don't know or trust, in a hospital you may not be comfortable with. While this Plan utilizes a Preferred Provider Option (PPO), you may still choose the doctor, surgeon, specialist and hospital you wish. Utilization of in-network physicians and facilities, however, is reimbursed at a higher rate. (Please see *How Does the PPO Work?* for details.)



## Join the Hundreds of TDA Members Already Covered!

This brochure provides complete coverage details for the Major Medical Insurance Plan. Plan highlights include:

- Comprehensive Preferred Provider Organization (PPO) Network
- Broad Coverage both In and Out of the Hospital
- Flexible Family Coverage Options
- Deductible Carry-Over Provision.

### Who Is Eligible?

You are eligible to apply provided you are a TDA Member, Team Member or Student Member under the age of 65 and residing in the state of Texas.

And thanks to your membership, your lawful spouse under age 65, and all unmarried dependent children (including adopted, stepchildren and grandchildren) up to age 25 are also eligible for coverage. Plus, once coverage for dependent children is in effect, any additional newborns are automatically covered from birth if the Administrator is notified in writing of the child's name and date of birth and the required additional premium is paid (if any) within 31 days from the date of birth.

A dependent who is a member must apply for member coverage. If both parents are insured as members, only one may request child coverage.

### Aggregate Benefit Maximum

**\$3 Million Aggregate Maximum Benefit** — This plan provides an overall aggregate maximum major medical benefit of \$3,000,000 per person for all covered expenses. There is a \$12,000 aggregate maximum benefit per person for treatment of Mental Disorders.

### The Deductible

TDA Members/Student Members may select an annual deductible of \$1,000, \$2,500, \$5,000 or \$10,000. The annual deductible for TDA Team Members is \$500 or \$1,000. The deductible applies separately to each insured family member each calendar year.

**Family Maximum:** If you have family coverage, once 2 family members have each satisfied their individual deductibles in a calendar year, no further deductible requirement will apply for that family for the balance of the year.

**Carry-Over Provision:** Expenses incurred during October, November and December which are not sufficient to satisfy the calendar year deductible may be applied to the deductible for the following year, if the next year's deductible is met within 12 months after the first expense is incurred.

**Common Accident:** If more than one insured family member is injured in the same accident, only one deductible will apply for all insured family members for that year for all covered expenses incurred as a result of the accident.

### How Does the PPO Work?

This plan features a Preferred Provider Organization (PPO) option through the Private Healthcare Systems (PHCS) Network. Discounted fees are offered by hospitals, physicians and other medical care providers participating in the PHCS PPO Network.

An **in-network provider** is a physician or facility which has contracted with PHCS to provide care to a group of insureds at a predetermined rate. **Out-of-network providers** are those who are not contracted with the Network.

Under this plan, if an in-network provider is used, your out-of-pocket expenses will be lower. (Please see *How the Plan Works* for details.) *However, the choice of providers is always up to the insured individual.*

To determine if your preferred physician or facility is a participant in the PHCS PPO Network you may call the Network's telephonic provider directory toll-free at 1-800-239-5523 or on the internet at <http://www.phcs.com>. (Once you have applied and been approved for coverage, the Plan Administrator will provide you with a PPO Directory that contains a complete listing of providers and an ID card that contains claims filing instructions.)

## How does the Plan Work?

Once an individual has satisfied his/her deductible (by incurring covered expenses equal to the deductible amount in a calendar year), the plan generally pays 80% of the next \$10,000 of covered expenses incurred through the PHCS PPO network (or 60% if incurred outside the PHCS PPO network). After that, the plan pays 100% of further covered expenses incurred for the rest of the calendar year.\*

Covered expenses for outpatient treatment of mental and nervous conditions are never paid at more than 80%.

\*Note: If you are confined in a hospital that is not in the PHCS PPO Network, an additional \$500 deductible will be applied. Also, failure to have a hospitalization pre-certified with Utilization Review (UR) will result in a 30% reduction in benefits for that confinement, to a maximum benefit reduction of \$1,000. (See *Pre-Certify Your Hospital Stays* with UR for details). These additional out-of-pocket costs cannot be included toward the \$10,000 maximum of coinsurance nor are they reimbursed at 100%.

## Covered Expenses

Covered Expenses are the usual and prevailing charges most other providers in the same locality would make for the same or comparable services or supplies, as:

- Medical treatment and surgical procedures by a doctor
- Prescription drugs
- Medical supplies, surgical dressings, blood, oxygen, and equipment
- X-rays, lab tests, and other diagnostic services
- Ambulatory Surgical Center charges
- Charges for private duty nursing to a maximum benefit of \$10,000 in a calendar year
- Hospital room and board and routine nursing charges up to semiprivate room charge
- Intensive care unit charge by a Hospital - up to three times the hospital's standard daily room and board rate.
- Skilled nursing facility confinement up to semiprivate room charge when in place of hospital confinement

- Medical services and supplies furnished by a hospital
- Anesthetics and administration
- Services of a licensed physiotherapist
- X-ray and radiation therapy
- Transportation to but not from a local hospital via ambulance. If special treatment is required and not available at a local hospital the Plan may also pay charges by a professional ambulance, railroad or regularly scheduled commercial passenger airline to the nearest hospital (within the U.S. and Canada) equipped to furnish the special treatment. See Certificate of Insurance for details.
- Artificial limbs and eyes for the initial replacement of a limb or eye lost while insured
- Lenses following cataract surgery
- Casts, splints, trusses, braces, crutches and surgical dressings
- Rental of a wheelchair and hospital bed, kidney dialysis, respiratory paralysis equipment and equipment for administration of oxygen
- Home health care (see Certificate of Insurance for certain limits)
- Speech and hearing therapy charges by a doctor, a licensed or certified speech therapist or audiologist for loss or impairment of speech or hearing.
- Repair of accidental injury to teeth if accident occurs while insured and treatment is incurred within 1 year of the accident
- Charges for routine mammographic examinations and pap smears when recommended by a doctor
- Hospice care (see Certificate of Insurance for limits)
- Prostate - specific antigen tests when recommended by a doctor.





## Other Covered Expenses

**Maternity Coverage** - Coverage is provided to members and spouses. Charges due to pregnancy are payable the same as for any other illness.

**Mental Disorders** - Charges to treat mental disorders are covered the same as any other illness subject to a \$1,500 calendar year benefit maximum and a \$12,000 aggregate benefit maximum while insured under the Plan.

**Coverage for Newborns** - Newborn infants are covered automatically from birth to 31 days. If the newborn child is the first child covered under the plan, notice of birth and the necessary additional premiums for child coverage must be provided to the Plan Administrator within 31 days of the child's birth, otherwise coverage will end.

Coverage for newborn children also includes the Hospital's charges for routine nursery care, room and board and the Doctor's charges up to the date the mother is discharged from the Hospital, but not beyond 5 days.

## Pre-Certify Your Hospital Stays with Utilization Review (UR)

Prior to a hospital confinement, you must call **PHCS** toll-free at **1-800-239-5523** to receive pre-certification.

For a non-emergency hospital admission, you must request precertification at least seven days prior - or as soon as possible if scheduled less

than seven days in advance of the planned admission. For maternity admission, it is preferable to initiate precertification by the start of the fourth month of pregnancy, but precertification must be requested at least seven days prior to admission.

In the event of an emergency admission, you or someone you appoint, must notify PHCS within two business days - or as soon as reasonably possible after admission. Patients who have their confinements arranged by a doctor participating in the PPO Network are not responsible for initiating precertification; instead the participating doctor initiates precertification.

**Please note** that precertification is a program utilized by New York Life to confirm the medical necessity of inpatient treatment. This determination is not medical advice. The final decision regarding your hospitalization rests with you and your physician. In addition, precertification does not guarantee benefit payments under the Plan.

**Failure to Precertify:** If you fail to call the UR Program as required, a penalty will apply. The benefits payable for that confinement will be reduced by 30% to a maximum benefit reduction of \$1,000. Any penalty amount for not complying with the UR program can not be used toward the deductible or out-of-pocket limit.

## Other Important Plan Provisions

### Coordination of Benefits

If you are insured under more than one group or franchise policy or governmental plan (including Medicare), benefits under this Plan will be coordinated with the other coverage so that you will not receive more than 100% of the total allowable medical expenses incurred from all such policies and plans.

### Right to Change Benefits or Rates

Future benefits are subject to change by agreement between New York Life and the Group Policyholder. Rates may be changed by New York Life on any premium due date and on any date on which benefits are changed.



## When Coverage Begins

All coverage is subject to underwriting approval by New York Life. Approved coverage will be effective on the first of the month following the approval provided the first premium is paid in a timely manner. You and your dependents to be insured must be performing the normal activities of a person in good health of like age as of the date coverage is effective.

## When Coverage Ends

Your coverage may be continued regardless of your age as long as you remain a TDA Member/Team Member\*, you pay your premiums when due and the Group Policy is not terminated. Coverage for your insured dependents can be continued so long as they meet the dependent status requirements\*, your coverage is in force and their premiums are paid in a timely manner. Should you die, your insured dependents can continue their coverage – See your Certificate for details.

The Group Policy is annually renewable at the option of the TDA. New York Life may terminate the Group Policy only if it terminates all Group Major Medical Policies issued to Association Groups in the state of Texas.

*\*Note: When an individual's coverage ends due to discontinuance of membership or dependent status requirements, he/she will have the opportunity to continue their coverage beyond their normal termination date.*

## Continuation of Coverage for A Handicapped Child

Coverage can continue on an insured child who is mentally or physically incapable of self-support, beyond the date it would ordinarily terminate because of attainment of the termination age, until the earlier of the date the

child is no longer so dependent or so handicapped, or the date the insurance would otherwise end.

## Incontestability

The validity of any amount of insurance which has been in force for two years during the insured's life will not be contested except for nonpayment of premium contributions.

## What is NOT Covered: Exclusions and Limitations

No benefits or limited benefits are payable for charges:

- Which are not specifically provided for.
- Resulting from losses due to war, or any action of war whether declared or undeclared.
- Incurred unless the insured is under the direct care of a legally qualified physician other than the insured or a member of his or her immediate family.
- For services or supplies for which the insured is not legally obligated to pay
- In excess of the reasonable and customary charge.
- Which are not necessary to the care or treatment of an illness or accident.
- For dental treatment (except this exclusion does not apply to hospital charges or charges for repair of natural teeth incurred as a result of and within twelve months after an accident nor does it apply to the repair of certain congenital problems).
- For purchase of eyeglasses, or contact lenses or the fitting thereof except in connection with cataract surgery.
- For services or supplies furnished by the U. S. or a foreign governmental agency, unless otherwise prohibited by law.
- Hospital charges for admission on a Friday and Saturday unless due to an accident or emergency illness, or, if surgery is performed within 24 hours after such admission.
- For professional services for manual manipulation of the spinal skeletal system and/or surrounding tissue, except as provided in the Certificate.
- For abortion unless medically necessary.

- Charges incurred while a person is not a Covered Person under the policy.
- For a nursing home.
- Related to a sex change.
- For care, treatment, services, drugs or supplies that are experimental or investigational in nature or inappropriate or unnecessary treatment.
- For treatment of refractive errors, including eye exams, radial keratotomy and other forms of surgery, eyeglasses or contact lenses.
- For cosmetic treatment or surgery, except payment will be made for cosmetic treatment or surgery due to an accident or a birth defect.
- For occupational therapy; custodial care; routine or preventative care (except as explained elsewhere).
- Charges due to a condition for which an Impairment Restriction has been placed on an individual's coverage.
- Incurred as result of any injury or sickness for which the insured would be eligible for Workers' Compensation.
- Benefits for treatment of infertility; foot care; immunizations; skilled nursing facilities; Home Health services; Hospice Care are limited as explained in the Certificate.

### Pre-Existing Condition Exclusion

No benefits are payable for an illness or injury due to a Pre-Existing Condition not disclosed on the application for coverage, until the earlier of:

- 12 consecutive months after the effective date of coverage during which no treatment or medical advice was received for that condition; or
- 24 consecutive months of coverage under this program.

A Pre-Existing Condition is any injury, sickness, mental, nervous or emotional disorder, or related illness for which a person consulted a doctor, received any medical services or supplies or took any medication during the 12 months immediately before becoming covered under this Plan and which was not disclosed on the person's request for coverage. A condition fully disclosed on the

application for insurance is not considered a Pre-Existing Condition. Please be aware, however, that failure to disclose a Pre-Existing Condition on your application could lead to future claim denial and rescission of your coverage.

All applications are subject to underwriting approval by New York Life as explained in the "When Coverage Begins" section.

### Risk-Free Opportunity

If you are not completely satisfied with your coverage, you may return your Certificate of Insurance within 30 days of receipt and your premium will be refunded in full. See enclosed Rate Sheet for your affordable Plan Premiums.

Courteous Service Representatives are available to assist you from 8:00 a.m. to 4:30 p.m., Central Time, Monday through Friday.

### It's Easy to Apply

1. Choose the deductible that applies to your membership level (\$1,000, \$2,500, \$5,000, or \$10,000 for TDA Members / Student Members, \$500 or \$1,000 for Team Members).
2. Indicate if you are applying for Spouse and/or Child(ren) Coverage.
3. Complete and sign the enclosed Application. Be sure to supply all requested information and answer all questions.
4. **Do not send any money now!** You will be billed for your first premium when your application is approved and your Certificate of Insurance is issued.

If you prefer the ease and convenience of having your premiums automatically deducted from your checking account via Electronic Funds Transfer (EFT) once your coverage is approved, simply call the Plan Administrator and the necessary form will be sent to you.

**If you have any questions,  
call the Marketing Agency TMGI at  
1-800-677-8644**



## For Members of the Texas Dental Association

Endorsed by TDA Financial Services, Inc. —  
An affiliate of the Texas Dental Association

Marketed by: TMGI  
P.O. Box 101356  
Fort Worth, TX 76185-1356



New or prospective applicants call: 1-800-677-8644  
FAX 1-817-569-8304

Administered by: NEBCO  
P.O. Box 153004  
Irving, TX 75015-3004

For Customer Service, Claims  
and Individual Medical Underwriting, call: 1-800-648-1258  
FAX 1-469-417-1676

Underwritten by: New York Life Insurance Company  
51 Madison Avenue,  
New York, NY 10010



*The Company You Keep<sup>®</sup>*

### NOTICE TO SMALL EMPLOYERS

This major medical insurance program underwritten by New York Life, is not a Small Employer Medical Plan. It does not comply with federal and state laws which act on employers who contribute to or provide insurance benefits for their employees. The program is intended for TDA Members, TDA Team Members, Student Members and their eligible dependents. Employees of Members are not eligible. TDA members who are interested in Small Employer Coverage may contact the Marketing Agency TMGI and request information about qualified Small Employer Plans which may be available.

This brochure provides a general description of the insurance plan offered and is not a contract. Complete terms, conditions, definitions, exclusions, limitations and renewability are detailed in Group Policy No. G-29074-0 (Policy Form GMR) and your Certificate of Insurance.