

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.

AFFORDABLE PREMIUMS. Please see the enclosed rate sheets for the current premium rates.

WHEN COVERAGE ENDS. Your coverage may be continued regardless of your age as long as you remain a TDA 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.



HOW TO OPEN AN ACCOUNT.

STEP ONE. ENROLL IN AN INSURANCE PLAN

Before you can open an HSA, you must be enrolled in a qualified High Deductible Health Plan with a minimum deductible for 2009 of \$1,150 (individual) or \$2,300 (family coverage).

STEP TWO. OPEN THE HEALTH SAVINGS ACCOUNT

Select a "Trustee". You may contact a local bank or other financial institution to act as a Trustee for your HSA. Or you may contact TMGI (800-677-8644) for a list of financial institutions that provide full service Health Savings Accounts.

STEP THREE. CONTRIBUTE TO THE HSA

Contributions may be made by an individual, employee and/or employer, in any combination. Your contributions are tax deductible. There is no legal minimum contribution, although your bank or trustee may require its own minimum. The annual contribution to an HSA is currently capped at \$3,000 for individuals or \$5,950 for families. These caps are scheduled to be indexed annually for inflation by the Treasury Dept. Account holders aged 55 and older may make additional "Catch-Up" contributions of \$1,000 in 2009 and after.

Your eligibility to contribute to your HSA for each month is generally determined by whether you have HDHP coverage on the first day of the month. Your maximum contribution for the year is the greater of (1) the full contribution allowed by law, or (2) the pro rated amount (1/12 of the full contribution allowed for the year for each month that you have HDHP coverage).

If you do not have HDHP coverage for the entire year, you will not be able to make the maximum contribution for that year unless you remain covered by an HDHP for the entire following year. If you fail to remain covered for the entire following year, the extra contribution above the pro rated amount for which you are eligible, including any catch-up contributions made, is included in income and subject to an additional 10 percent penalty. Contributions can be made as late as April 15th of the following year.

Your Bank/Trustee should send you periodic statements on your account balance. Remember, any interest income or earnings accumulate tax-free in your account. Any savings not used can accumulate year after year – there is no "use it or lose it" provision. After age 65 the funds in the HSA can even be used to fund your retirement needs with withdrawals only subject to normal federal income tax.

SOME IMPORTANT NOTES. The Texas Dental Association, through its affiliate TDA Financial Services, Inc., currently makes available to their members a High Deductible Health Insurance Plan (HDHP) designed to be HSA-qualified. The plan is underwritten by New York Life Insurance Company (51 Madison Avenue, New York, NY 10010). The Texas Dental Association, TDA Financial Services, Inc., TMGI, NEBCO, and New York Life bear no responsibility for the establishment or administration of any Health Savings Account (HSA) you may open.

NOTE: We cannot give, and this brochure is not intended, as legal or tax advice. We strongly urge that you consult with your accountant or tax advisor before opening an HSA to determine if this savings vehicle is available to and appropriate for you.

HEALTH SAVINGS ACCOUNT (HSA) – QUALIFIED HIGH DEDUCTIBLE HEALTH INSURANCE PLAN (HDHP)

WHO IS ELIGIBLE? You are eligible to apply provided you are a TDA Member/Team 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.

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 \$10,000 benefit maximum per person per year and a \$30,000 aggregate benefit maximum per person for treatment of Mental Disorders.

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.)



IT'S EASY TO APPLY.

1. Indicate the plan option for which you are applying and whether for the Individual or Family Deductible.
2. Complete and sign the enclosed Application. Be sure to supply all requested information and answer all questions.
3. 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.

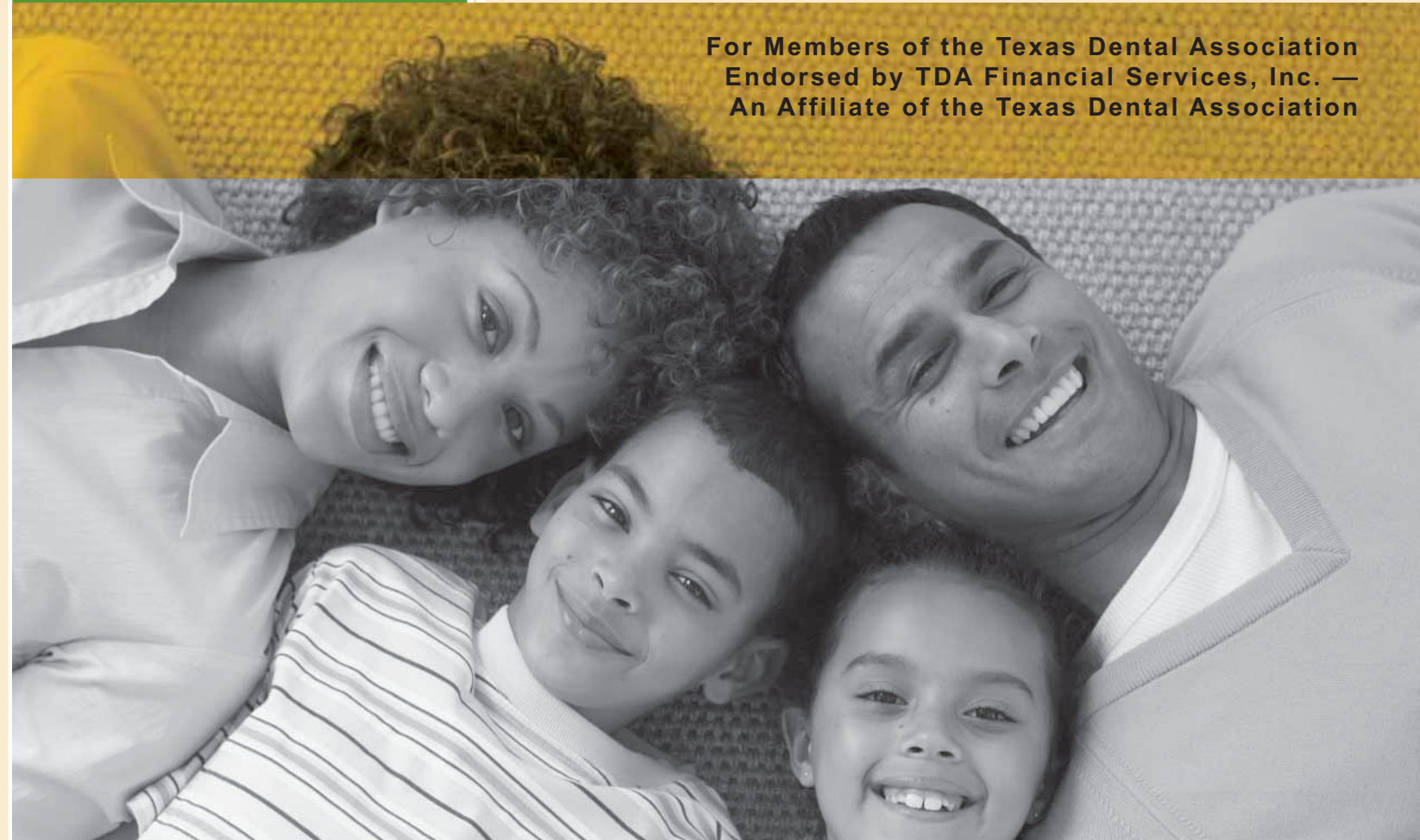
If you prefer the ease and convenience of having your premiums automatically deducted from your checking account via Electronic Funds Transfer (EFT) once your coverage is approved, please be sure to complete the Check-Matic request section on the Application.



AN ALTERNATE APPROACH TO FUNDING HEALTH CARE COSTS
Designed Specifically for Dentists and Their Families

A HEALTH SAVINGS ACCOUNT (HSA) QUALIFIED GROUP HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

**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

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: 1-469-417-1675

UNDERWRITTEN BY:

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010

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 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.

Endorsed by:
TDA Financial Services, Inc. (FSI)
An Affiliate of the
Texas Dental Association

Underwritten by:
New York Life Insurance Company

TDAHDP REV 01/09

With the cost of health care and health insurance continuing to rise, many Dentists are looking for options and alternatives. Dentists want protection for themselves and their families from potentially high financial losses that may result from hospitalizations or other catastrophic medical events, but also want to keep their premiums down. For the Dentist that is comfortable with paying for some of the first dollar medical expenses like prescription drugs and office visits, the solution might be a Qualified High Deductible Health Plan (HDHP) combined with a Health Savings Account (HSA).

Questions? 1-800-677-8644

WHAT IS A HIGH DEDUCTIBLE HEALTH INSURANCE PLAN? A Qualified HDHP is a health insurance plan that must meet federal guidelines with regard to benefits, deductibles, annual out of pocket maximums and other requirements. These amounts are determined by the federal government and may change from year to year. Under a Family High Deductible Health Plan, there is one family deductible and all members of the family contribute to that deductible. For High Deductible Health Plans, a family is defined as two or more insureds. It is important to remember that just having a high deductible does not mean you are eligible to open an HSA.

WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)? The Health Savings Account (HSA) is your personal and portable savings account into which you may deposit pre-tax dollars, and then withdraw tax-free dollars to pay for eligible medical expenses not covered by your health insurance plan. HSAs allow you to roll over unused funds from year to year, and allow you to take your account with you if you change jobs or health insurance coverage. Eligible withdrawals are not taxed as income. Money withdrawn for ineligible expenses prior to age 65 is subject to federal income tax plus a 10% penalty. At age 65, money withdrawn for non-qualified expenses is subject only to federal income tax with no penalty. There is no minimum distribution requirement. Upon your death if your spouse becomes the owner of the account, your spouse can use it as if it were his or her own HSA. If you are not married, the account will no longer be treated as an HSA but will pass to a beneficiary for use like any other asset of your estate, subject to any applicable taxes.

WHO IS ELIGIBLE? In general, anyone under age 65 with coverage under a Qualified High Deductible Health Plan (HDHP) and no other first-dollar medical coverage is eligible to open an HSA. If you or any of your dependents are covered under another health insurance program, enrolled in Medicare, or can be claimed as a dependent on someone else's tax return, it could affect your eligibility for a tax advantaged HSA, so you should consult with your accountant or tax advisor to determine your eligibility.

WITHDRAWALS FROM YOUR HSA You may withdraw funds from your HSA to reimburse yourself for any "qualified medical expense" permitted under federal tax law. This includes most medical care and services, dental and vision care, and also includes over-the-counter drugs such as aspirin. Withdrawals are optional. You may choose to retain funds in your HSA, and allow the money to continue to grow tax-free. Some examples of withdrawals you may decide to take might include ...

- During the year, your family accumulates a variety of medical bills, including doctor visits, prescription drugs, and clinical care totaling \$900. These are eligible expenses, but do not exceed your family deductible. You may withdraw the \$900 tax-free from your HSA as reimbursement.
- You decide to purchase Long-Term Care insurance. You fund your annual \$1,700 premium with tax-free HSA funds.
- Over the years you've accumulated \$15,000 in your HSA and decide to withdraw the entire amount for college expenses. You may withdraw the money, but the money is subject to federal income tax plus a 10% penalty if you are under age 65. If age 65 or older, the money is subject to federal income tax only.

Qualified medical expense withdrawals are tax free. Dollars can be used to pay for some items and services usually not covered by health insurance such as dental care, eye glasses, contact lenses and much more. These eligible expenses are described in Section 213(d) of the Internal Revenue Code.

DESIGNED WITH YOUR NEEDS IN MIND.

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.
- For 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.
- 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).

- 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.
 - In excess of the specified maximums.

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:
a) 12 consecutive months after the effective date of coverage during which no treatment or medical advice was received for that condition; or **b)** 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 8:30 a.m. to 4:30 p.m., Central Time, Monday through Friday.



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 Does the Plan Work* 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 www.multiplan.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?

PLAN OPTIONS. Members may elect one of the following High Deductible Health Plans (HDHPs) with either an Individual or Family Deductible.

Member HDHP 1A - \$1,500 Individual Deductible \$3,000 Family Deductible	Member HDHP 1 - \$3,000 Individual Deductible \$6,000 Family Deductible	Member HDHP 2 - \$5,000 Individual Deductible \$10,000 Family Deductible
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Team Members may elect one of the following HDHPs with either an Individual or Family Deductible.

Team Member HDHP 3 - \$1,500 Individual Deductible \$3,000 Family Deductible	Team Member HDHP 4 - \$3,000 Individual Deductible \$6,000 Family Deductible
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ABOUT THE INDIVIDUAL DEDUCTIBLE. The Individual Deductibles are only available to Members/Team Members. Under the Individual Deductible, the insured Member/Team Member must incur the applicable amount of covered expenses in a calendar year before benefits will be paid.

ABOUT THE FAMILY DEDUCTIBLE. Under the Family Deductible, the insured Member/ Team Member and their insured family members (spouses and/or children) must collectively incur the applicable amount of covered expenses in a calendar year before benefits will be paid. (Note: an individual deductible does not apply under the family deductible.)

BENEFIT PAYMENTS BEGIN AFTER SATISFACTION OF THE DEDUCTIBLE.

FOR MEMBERS CHOOSING HDHP 1A OR 1 OR TEAM MEMBERS CHOOSING HDHP 3 OR HDHP 4 Under the **Individual Deductible** the plan then pays 80% of covered in-network expenses that are incurred (60% of covered out-of-network expenses). Once the Member's out-of-pocket (including the Deductible) totals \$5,000 for in-network expenses (\$7,500 for out-of-network expenses) the plan pays 100% for the remainder of the calendar year. **Under the Family Deductible** the plan then pays 80% of covered in-network expenses that are incurred (60% of covered out-of-network expenses). Once the family's out-of-pocket (including the Deductible) totals \$10,000 for in-network expenses (\$15,000 for out-of-network expenses) the plan pays 100% for the remainder of the calendar year.

FOR MEMBERS CHOOSING HDHP 2 Under the **Individual Deductible** the plan then pays 100% of all covered in-network expenses that are incurred for the remainder of the calendar year (80% of covered out-of-network expenses). Once the Member's out-of-pocket (including the Deductible) totals \$7,500 for out-of-network expenses, the plan pays 100% for the remainder of the calendar year. **Under the Family Deductible** the plan then pays 100% of all covered in-network expenses that are incurred for the remainder of the calendar year (80% of covered out-of-network expenses). Once the Family's out-of-pocket (including the Deductible) totals \$15,000 for out-of-network expenses, the plan pays 100% for the remainder of the calendar year.

Note: An additional Deductible of \$500 will apply to all HDHP's for Hospitalizations that are not pre-certified with Utilization Review (UR). This additional Deductible does not count toward satisfying the Individual or Family Deductible, does not count toward satisfying the "out-of-pocket" maximum and is not reimbursed under the Plan – See "Pre-Certify Your Hospital Stays with Utilization Review (UR)" for details.

WHAT EXPENSES ARE COVERED.

COVERED EXPENSES. Covered Expenses are limited to the usual and prevailing charges most other providers in the same locality would make for the same or comparable services or supplies. Covered Expenses include:

- 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.
- See the Certificate of Insurance for complete details of all Covered Expenses.

OTHER COVERED EXPENSES

MATERNITY COVERAGE - Coverage is provided to Members and spouses and Team Members. 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 \$10,000 calendar year benefit maximum and an aggregate benefit maximum of \$30,000 while insured under the policy.

COVERAGE FOR NEWBORNS - Newborn infants are covered automatically from birth to 31 days. 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 pre-certification 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 pre-certification by the start of the fourth month of pregnancy, but pre-certification 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 pre-certification; instead the participating doctor initiates pre-certification.

Please note that pre-certification 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, pre-certification does not guarantee benefit payments under the Plan.

FAILURE TO PRE-CERTIFY: If you fail to call the UR Program prior to any Hospital Confinement an additional \$500 Deductible will apply. This additional Deductible does not count toward satisfying the Individual or Family Deductible, does not count toward satisfying the "out-of-pocket" maximum and is not reimbursed under the Plan.