



# AVMA | GHLIT



Group Health & Life  
Insurance Trust Programs

## MEDICAL PLANS

**Designed  
by Veterinarians  
for Veterinarians**

Valuable Benefits.  
Remarkable Service.



Underwritten by New York Life Insurance Company

# *Medical Plans*

## The Only Health Insurance That's Only For Veterinarians

Since 1957, The American Veterinary Medical Association Group Health and Life Insurance Trust (AVMA GHLIT) has made available to members like you coverage you can trust.

This group health and life insurance trust program is tailor-made for veterinarians, by veterinarians. Members in the program are more than just participants – they're in charge.

Ten Trustees, all AVMA members, supervise the program and its professional operating staff. They give the plan direction, to be sure the benefits are the ones you and your family most desire. The Trustees also act as a Review Board should a member ever experience a problem with the insurance program. You can think of it as having a "Board of Directors" that puts your needs first.

The program is also designed to help save you money. You'll benefit from the group purchasing power of thousands of veterinarians across the country.

As a self-rated participating program, charges to members are based on the claims experience of AVMA members and their families – no outside groups. When funds exceed expenses, that money is returned to participants in the form of lower costs or improved coverage.

The program is underwritten by New York Life Insurance Company, one of the industry's most respected names.

## A CHOICE OF PLANS

The AVMA GHLIT offers a selection of plans, to fit your lifestyle and your budget. Each offers its own advantages.

### Preferred Provider Organization (PPO) Plans

The PPO plans offer you savings by utilizing a leading national network of providers. PPO plans offer other options, including lower deductibles, in-network doctor office visits, and prescription drug co-pays. You will also have available to you a strong and broad provider network.

### PPO Value Plans

PPO Value plans offer higher deductibles to lower your monthly costs, as well as additional co-pays (or deductibles) on certain services that result in lower rates to you. Options include the ability to use in-network or out-of-network providers.

### Traditional Major Medical Plans

These plans provide generous benefit coverage and the freedom to choose any doctor. Deductible options range from \$500 to \$5,000, with very reasonable out-of-pocket stop-loss maximums, regardless of the providers chosen.

### High Deductible/Health Savings Account (HSA) Qualified Plans

These plans are designed to comply with the government rules on Health Savings Accounts (HSAs) and allow you to establish an HSA, a tax-advantaged way to self-insure against future health care expenses. HSA plans are available to eligible members and their families.

### Some Important Benefits of the PPO Plans

#### Convenience

We've teamed up with The **First Health**® Network, one of the nation's largest directly contracted national networks, to offer in-network providers, and to make it easy for you to choose among some of your area's physicians and specialists.

#### Savings and Choice

You enjoy greater savings when you use an in-network provider; however, the choice of a health care provider is always yours. The plan pays benefits both in and out of the network.

#### No Primary Care Referrals Required

Unlike many managed health care plans, you are free to go to any doctor or specialist without the expense and effort of first getting a referral from a specified primary care physician.

# AVMA GHLIT PPO COVERAGE

## Liberalized Deductibles

Special rules apply in the following circumstances:

- If two or more family members incur eligible expenses to treat injuries suffered in the same accident, only one deductible will apply to these expenses in that year and in the following year.

## \$20 Doctor Office Visits

If your physician is a participant in The **First Health**® Network, you pay only \$20 for a doctor's office visit. This \$20 co-pay does not count toward satisfying your deductible, and is not applied to your co-insurance maximum. Out-of-network doctor visits are paid differently: These visits are subject to the out-of-network deductible and co-insurance provisions.

## Optional Maternity Benefits (See Page 7 for description)

## Prescription Coverage

There are three levels of co-pays for prescription drugs:

	PHARMACY	MAIL ORDER
1) Generic	\$15	\$30
2) Preferred Brands	\$25	\$50
3) Other brand name drugs	\$35	\$70

These co-pays apply when you present your prescription drug ID card to a pharmacy that participates in the Medco network. With mail order, you can receive an extended supply of medication. Prescription drug co-pays are not applied to the deductible or co-insurance maximum. If a Medco network pharmacy is not used, eligible charges for outpatient prescription drugs will be subject to the out-of-network deductible and co-insurance limits. **See coverage details for limitations.**

## Important Protection: Stop-Loss Co-Insurance Maximum

This plan is designed to limit the amount of expenses you pay out of your own pocket in a calendar year. After your deductible has been satisfied the plan pays 80% on the next \$5,000 of eligible expenses incurred in-network and 60% of out-of-network expenses. The plan then pays 100%\* of additional eligible expenses incurred in that calendar year.

\*Eligible expenses for nursing care, gastric bypass surgery, infertility treatment, and the treatment of psychiatric conditions, drug abuse and alcoholism, however, are limited as explained in the Exclusions and Limitations section of this brochure. These expenses (with the exception of nursing care expenses) and any additional deductibles that may be imposed if a hospital stay is not approved in the Pre-admission Certification process, as well as any co-pays and any eligible expenses that are paid at 100%, are not included for purposes of reaching the co-insurance "stop loss maximum".

## PPO Plans

Deductible	PLATINUM PLAN		GOLD PLAN		BRONZE PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual	\$250	\$750	\$500	\$1,000	\$1,000	\$1,500
Family	\$750	\$2,250	\$1,500	\$3,000	\$3,000	\$4,500
Co-Insurance Levels	80/20	60/40	80/20	60/40	80/20	60/40
Doctor Office Visit	\$20 co-pay per visit	Deductible & co-insurance	\$20 co-pay per visit	Deductible & co-insurance	\$20 co-pay per visit	Deductible & co-insurance
Co-Insurance Limits*	\$5,000 after deductible		\$5,000 after deductible		\$5,000 after deductible	
Hospitalization**	Deductible & Co-insurance		Deductible & Co-insurance		Deductible & Co-insurance	
Lifetime Maximum	\$5 million		\$5 million		\$5 million	
Adult Wellness	Up to \$300 first dollar calendar year benefit. Expenses in excess of \$300 are subject to Deductible and Co-insurance					
Children's Routine Wellness	Up to \$300 first dollar calendar year benefit. Expenses in excess of \$300:					
Prescription Drugs	<b>In-Network</b>		<b>Out-of Network</b>			
	\$20 co-pay per visit		Deductible and Co-insurance			
	<b>In-Network Pharmacy</b>		<b>Out-of Network Pharmacy</b>			
	\$15 co-pay for generic (30 day supply)		Deductible & Co-insurance			
	\$25 co-pay for preferred brands (30 day supply)					
\$35 co-pay for other brand name drugs (30 day supply)						
Mail order available for 2x co-pay (up to 90 day supply)						

\*Based on eligible expenses incurred in calendar year.

\*\*Subject to an additional \$250 deductible if hospitalization is not pre-certified.

For a list of **First Health**® Network participants in your area, visit [www.avmaghlit.org](http://www.avmaghlit.org) or call 1-800-621-6360.

## Some Important Benefits of The PPO Value Plans

The PPO Value Plans provide affordable insurance alternatives with the power of choice. You can choose from five levels with distinct coverage options. And no matter which level you choose, you always have the freedom to select from the list of in-network providers, or your own out-of-network source.

### The Marriage Of Value and Choice

Both in and out of network, the PPO Value Plans offer you and your family a variety of flexible coverage options to offset the rising costs of healthcare.

- **Deductibles.** You can select an individual annual deductible ranging from as low as \$250 (in-network) or \$750 (out-of-network) to as high as \$5,000 (in-network) or \$7,500 (out of network). The family deductible equals three times the individual deductible.
- **Stop Loss Co-insurance.** After the deductible is satisfied, the plan pays 80%\* of eligible expenses incurred through The First Health Network, or 60%\* if incurred outside the network on the next \$10,000 of eligible expenses for an individual or \$30,000 for a family. Thereafter, most eligible expenses\* incurred that calendar year are payable at 100%\*\*
- **Special Deductibles.** Additional deductibles of \$250 (in network) and \$500 (out-of-network) help keep the plans affordable. They apply to Out-Patient Surgical (per procedure), CT Scan/MRI Out-Patient (per procedure) and Emergency Room (per visit – waived if admitted.) Emergency Room deductible is \$250 whether in-network or out-of-network. These deductibles are in addition to the individual annual deductible and co-insurance.

### \$35 Doctor Visits

On Plans F, K, and L, an office visit to a physician in The **First Health**® Network costs you just \$35. This co-pay does not count towards satisfying your deductible and is not applied to your co-insurance maximum. Out-of-network doctor visits are paid differently: These visits are subject to the out-of-network deductible and co-insurance.

### Prescription Coverage

When you present your prescription drug ID card to a pharmacy that participates in the Medco network, the following co-pays apply:

- \$15 co-pay for generic
- \$25 co-pay for preferred brands + 20% co-insurance (up to 30 day supply)
- \$35 co-pay for other brand name drugs + 40% co-insurance (up to 30 day supply)
- Mail order available for 2x co-pay + applicable co-insurance (up to 90-day supply)

Prescription drug co-pays are not applied to the deductible or co-insurance maximum. If a Medco network pharmacy is not used, eligible charges for outpatient prescription drugs will be subject to the out-of-network deductible and co-insurance limits. See coverage details for limitations.

\*Excludes hospital pre-admission certification deductible penalty, special deductibles, co-pays and those gastric bypass, infertility treatment and psychiatric expenses which are reimbursed at 50%.

## PPO Value Plans

Deductible	PLAN F		PLAN K		PLAN L		PLAN R		PLAN T	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual	\$250	\$750	\$500	\$1,000	\$1,000	\$1,500	\$2,500	\$3,750	\$5,000	\$7,500
Family	\$750	\$2,250	\$1,500	\$3,000	\$3,000	\$4,500	\$7,500	\$11,250	\$15,000	\$22,500
Co-Insurance Levels	80/20	60/40	80/20	60/40	80/20	60/40	80/20	60/40	80/20	60/40
Co-Insurance Limits**	To \$10,000		To \$10,000		To \$10,000		To \$10,000		To \$10,000	
Individual	After Deductible		After Deductible		After Deductible		After Deductible		After Deductible	
Family	To \$30,000		To \$30,000		To \$30,000		To \$30,000		To \$30,000	
	After Deductible		After Deductible		After Deductible		After Deductible		After Deductible	
Doctor Office Visit	\$35 co-pay per visit	Deductible & Co-insurance	\$35 co-pay per visit	Deductible & Co-insurance	\$35 co-pay per visit	Deductible & Co-insurance	Deductible & Co-insurance	Deductible & Co-insurance	Deductible & Co-insurance	Deductible & Co-insurance
Hospitalization*	Deductible & Co-insurance		Deductible & Co-insurance		Deductible & Co-insurance		Deductible & Co-insurance		Deductible & Co-insurance	
Adult Wellness	Up to \$300 first dollar calendar year benefit. Expenses in excess of \$300 are subject to Deductible and Co-insurance.									
Children's Routine Wellness	Up to \$300 first dollar calendar year benefit Expenses in excess of \$300:						Up to \$300 first dollar calendar year benefit. Expenses in excess of \$300 subject to deductible and co-insurance.			
	<b>In-Network</b>			<b>Out-of Network</b>						
	\$35 co-pay per visit			Deductible and Co-insurance						
Additional Deductible	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Out-Patient Surgical (per procedure)	\$250	\$500	\$250	\$500	\$250	\$500	\$250	\$500	\$250	\$500
CT Scan/MRI Outpatient (per procedure)	\$250	\$500	\$250	\$500	\$250	\$500	\$250	\$500	\$250	\$500
ER (per visit) Waived if admitted	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250
Lifetime Maximum	\$5 million		\$5 million		\$5 million		\$5 million		\$5 million	
Prescription Drugs	<b>In-Network Pharmacy</b> \$15 co-pay for generic \$25 co-pay for preferred brands + 20% co-insurance (up to 30-day supply) \$35 co-pay for other brand name drugs + 40% co-insurance (up to 30-day supply) Mail order available for 2x co-pay + applicable co-insurance (up to 90-day supply)						<b>Out-of-Network Pharmacy</b> Deductible & Co-insurance			

\*Subject to an additional \$250 deductible if hospitalization is not pre-certified.

\*\*Based on eligible expenses received in calendar year.

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### Optional Maternity Benefits for the PPO and PPO Value Plans

In order to provide members with more flexibility in determining their plan design and the cost of their coverage an Optional Maternity Benefit has been introduced. Under the PPO and PPO Value plans you make decisions of whether or not you want coverage for the eligible expenses incurred for a normal pregnancy.

If you elect Optional Maternity Benefits the plan can pay up to \$3,000 in benefits per pregnancy after these benefits have been in force for twelve (12) months. (During the first 12 months of coverage, the benefits are limited to no more than \$1,500 per pregnancy and are payable at 50%

whether in or out of network, after the applicable deductible has been satisfied.) After 12 months, eligible expenses incurred for normal pregnancy, including delivery, are covered subject to the applicable plan deductible and co-insurance provisions.

In addition, if Optional Maternity Benefits are elected by the insured mother, eligible expenses for the newborn baby will be covered subject to the child's own deductible and co-insurance limits.

If you choose not to elect the Optional Maternity Benefits, the charges for a normal maternity incurred by an insured member, spouse or dependent child will not be considered

eligible expenses under the policy. This also includes any expenses incurred by a newborn baby in the hospital after delivery.

Whether the Optional Maternity Benefits are elected or not, any charges arising from complications of childbirth such as surgery and related medical care required for caesarean section, extrauterine pregnancy, complications requiring intra-abdominal surgery after termination of pregnancy, and pernicious vomiting or toxemia and convulsions while hospitalized, will be considered eligible expenses under the policy and will be covered subject to the applicable plan deductible and co-insurance provisions.

Please note that California, Montana and Minnesota mandate maternity benefits must be included as part of the medical plan and are treated as any other illness.

## AVMA GHLIT TRADITIONAL MAJOR MEDICAL PLANS

### Some Important Benefits of Traditional Medical Coverage

Our Traditional Major Medical plans offer you the freedom to choose any provider, while providing generous co-insurance levels and a choice of deductible.

#### Choose Your Individual Deductible

Select among four levels, from as low as \$500 per year for individual coverage, up to \$5,000.

#### Family Deductibles

Traditional Major Medical Plans C and D family deductibles will be considered satisfied in a calendar year when the amount of eligible expenses applied to their individual deductibles totals three times the amount of the individual deductible. Plans X and Y family deductibles will be considered satisfied in a calendar year when the amount of eligible expenses applied to their individual deductibles totals two times the amount of the individual deductible.

#### Liberalized Deductibles

Special rules apply in the following circumstances:

If two or more family members incur eligible expenses to treat injuries suffered in the same accident, only one deductible will apply to these expenses in that year and in the following year.

#### Important Protection: Stop-Loss Co-Insurance<sup>†</sup>

The plans are designed so that the maximum out-of-pocket expenses you pay each year are limited. Here's how it works: After your deductible has been satisfied, the plan pays 80% (70% if hospitalized in an out-of-network hospital) of the next \$5,000, and then pays 100% of most additional eligible expenses incurred that calendar year.

Here's how it works for families: After the family deductible has been satisfied, the plan pays 80% (70% if hospitalized in an out-of-network hospital) of the next \$10,000, and then 100% of most additional eligible expenses incurred in that calendar year.

<sup>†</sup>See Exclusions and Limitations for additional details on reaching the stop-loss limit.

## Traditional Major Medical Plans

	PLAN C	PLAN D	PLAN X	PLAN Y
Deductible Individual	\$500	\$750	\$1,500	\$5,000
Deductible Family	\$1,500	\$2,250	\$3,000	\$10,000
Co-Insurance Levels <sup>1</sup>	80/20	80/20	80/20	80/20
Co-Insurance Limits <sup>2</sup> Individual	To \$5,000 after Deductible	To \$5,000 after Deductible	To \$5,000 after Deductible	To \$5,000 after Deductible
Co-Insurance Limits <sup>2</sup> Family	To \$10,000 after Deductible	To \$10,000 after Deductible	To \$10,000 after Deductible	To \$10,000 after Deductible
Doctor Office Visit	Deductible & Co-insurance	Deductible & Co-insurance	Deductible & Co-insurance	Deductible & Co-insurance
Hospitalization <sup>1,3</sup>	Deductible & Co-insurance	Deductible & Co-insurance	Deductible & Co-insurance	Deductible & Co-insurance
Maternity	Deductible & Co-insurance	Deductible & Co-insurance	Deductible & Co-insurance	Deductible & Co-insurance
Adult Wellness	Deductible & Co-insurance	Deductible & Co-insurance	Deductible & Co-insurance	Up to \$300 first dollar calendar year benefit. Expenses in excess of \$300 are subject to Deductible and Co-insurance.
Well Baby Care	Deductible & Co-insurance	Deductible & Co-insurance	Deductible & Co-insurance	Deductible & Co-insurance
Children's Routine Wellness	Deductible & Co-insurance	Deductible & Co-insurance	Deductible & Co-insurance	Up to \$300 first dollar calendar year benefit. Expenses in excess of \$300 are subject to Deductible and Co-insurance.
Lifetime Maximum	\$ 5 million	\$ 5 million	\$ 5 million	\$ 5 million
Prescription Drugs Deductible	\$200	\$300		
Reimbursement Generic	80%	80%	Deductible & Co-insurance	Deductible & Co-insurance
Reimbursement Preferred	70%	70%		
Reimbursement Brand	60%	60%		
Coinsurance Limit	*100%	**100%		
Mail Order Benefit	***	***		

\*After \$2,000 of eligible prescription calendar year drug expenses have been incurred by insured once deductible is satisfied.

\*\*After \$2,500 of eligible prescription calendar year drug expenses have been incurred by insured once deductible is satisfied.

\*\*\*Mail order prescriptions would be paid on the same basis as scheduled above

**<sup>1</sup>Coinsurance level will be reimbursed at 70% if hospitalized in an out-of-network hospital. Some benefits are paid at 50%, and are not applied to the out-of-pocket limit.**

<sup>2</sup>Based on eligible expenses received in calendar year.

<sup>3</sup>Subject to an additional \$250 deductible if hospitalization is not pre-certified.

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# THE HEALTH SAVINGS ACCOUNT CONCEPT

The Health Savings Account (HSA) is your personal and portable savings account in 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 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 regular federal income tax plus a 10% penalty. On or after age 65, money withdrawn for ineligible expenses is subject only to income tax.

## **Eligibility**

Anyone under age 65, with a qualified high-deductible health insurance plan is eligible to open an HSA.

## **How To Open An Account**

### **Step 1: Enroll In An Insurance Plan**

Before you open an HSA, you must be enrolled in a qualified high deductible health insurance plan with a minimum deductible of \$1000 (individual) or \$2000 (family coverage).

### **Step 2: Open The Health Savings Account**

Select a "Trustee," or bank, in which to open your HSA. You may contact the Trust Office for a list of financial institutions that provide full service Health Savings Accounts. Or you may contact a local bank to act as a Trustee for your HSA.

### **Step 3: Contribute to the HSA**

You may contribute up to 100% of your deductible each year, with a cap of \$2,750 for individuals or \$5,450 for families. Your initial contribution will be pro-rated based on when you establish your HSA. (For example, if you open an account July 1, you may deposit 1/2 your annual maximum that calendar year.)

Contributions may be made by an individual, employee and/or employer, in any combination. There is no legal minimum contribution, although your bank may require its own minimum. Account holders aged 55 and older may make additional contributions of \$700 in 2006, increasing by \$100 each year to a maximum of \$1,000 in 2009.

Your Bank/Trustee should send you periodic statements on your account balance. Remember, any interest income accumulates tax-free in your account.

## **Withdrawals From Your HSA**

You may withdraw funds from your HSA to reimburse yourself for medical expenses not paid under your HSA-qualified health insurance plan, such as deductibles or co-insurance. Any other medical-related charges not covered by your health insurance plan also qualify for reimbursement. 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:

- 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 to pay 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 65 or older, you are subject to federal income tax only.
- Upon retirement, you begin paying Medicare health insurance premiums. You can fund the premiums, tax-free, with your HSA funds.

Your Bank/Trustee should provide you with the guidelines and procedures on what constitutes qualified expenses for reimbursement, and how to submit for reimbursements.

We cannot give, and this information 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.

The American Veterinary Medical Association, through the AVMA Group Health & Life Insurance Trust, offers members a High Deductible Health Insurance Plan designed to be HSA-qualified. The plan is underwritten by New York Life Insurance Company (51 Madison Ave., New York, NY 10010). The Trust and New York Life bear no responsibility for the establishment or administration of any Health Savings Account(s) you may open.

Please note that if you or any of your dependents are covered under another health insurance program, it could affect your eligibility for a tax advantaged HSA. You should consult with your accountant or tax advisor to determine if you are eligible for an HSA.

# AVMA GHLIT HIGH DEDUCTIBLE/ HSA QUALIFIED COVERAGE

## AVMA GHLIT High Deductible/HSA Qualified Coverage

If you are an AVMA member under age 65, you may apply to insure yourself, your spouse, and unmarried dependent children under age 23. Underwritten by New York Life and approved by the AVMA GHLIT, these high-deductible health insurance plans offer medical coverage of up to \$5 million for eligible expenses, a choice of 4 individual or family deductibles, and a stop-loss feature for your protection. The higher the deductible, the lower the cost of the plan. You should consult with your accountant or tax advisor to determine if these plans are right for you and your family.

### **About the Individual Deductible Amount**

Under the Individual Deductible Plans, the insured member must incur the applicable deductible amount of eligible expenses in a calendar year before benefits will be paid.

The Individual Deductible Plans are only available to members.

### **About the Family Deductible Amount**

Under the Family Deductible Plans, the member and his/her insured family members must incur the applicable amounts of eligible expenses in a calendar year before benefits will be paid. The Family Deductible plans are available to member and spouse and member and children and member, spouse and children. The Individual Deductible does not apply under the Family Deductible Plan.

### **Payments are made after the Deductible amount is satisfied**

With the exception of the \$5,000 Individual Deductible/\$10,000 Family Deductible Plan, under the Individual Deductible Plans, the insured member must first satisfy the calendar year deductible, then the plan pays 80% of eligible in-network/60% of eligible out-of-network expenses incurred in the calendar year until the member's out of pocket (including the deductible) totals \$5,000 for in-network expenses/\$7,500 for out-of-network expenses.

Under the Family Plans, the insured family must satisfy the calendar year deductible, then the plan pays 80% of eligible in-network/60% of eligible out-of-network expenses incurred in the calendar year until the family's out of pocket (including the deductible) totals \$10,000 for in-network expenses/\$15,000 for out-of-network expenses.

Under the \$5,000 Individual/\$10,000 Family Deductible Plan, the insured member or family members must first satisfy the deductible then the plan pays 100% of eligible in-network expenses incurred in the calendar year. For out-of-network expenses, the plan pays 80% of eligible expenses incurred in the calendar year until the member's out of pocket (including the deductible) totals \$7,500 per Individual/\$15,000 per Family.

**Note:** For all plans, some eligible expenses for gastric bypass surgery and treatment of psychiatric conditions, drug abuse and alcoholism are paid at 50%.

## HSA Qualified Plans

CHOICE OF PLANS	PLAN S1		PLAN S2		PLAN S3		PLAN S4	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Deductible								
Individual		\$1,500		\$2,600		\$3,500		\$5,000
Family		\$3,000		\$5,200		\$7,000		\$10,000
Co-insurance Levels								
Individual	80/20	60/40	80/20	60/40	80/20	60/40	100%	80%
Family	80/20	60/40	80/20	60/40	80/20	60/40	100%	80%
Out-of-Pocket Limits*								
Individual	\$5,000	\$7,500	\$5,000	\$7,500	\$5,000	\$7,500	N/A	\$7,500
Family	\$10,000	\$15,000	\$10,000	\$15,000	\$10,000	\$15,000	N/A	\$15,000
Lifetime Maximum		\$5 million		\$5 million		\$5 million		\$5 million
Adult Wellness	Up to \$300 first dollar calendar year benefit. Expenses in excess of \$300 are subject to Deductible and Co-insurance							
Children's Routine Preventive Care	Up to \$300 first dollar calendar year benefit. Expenses in excess of \$300 are subject to Deductible and Co-insurance							

**Once the out-of-pocket maximums have been reached, benefits are paid at 100% for the balance of that calendar year.**

\*Based on eligible expenses incurred in calendar year and paid by insured.

## COVERAGE DETAILS

### Most AVMA members are eligible to apply

Regular AVMA members under age 65 may apply to insure themselves and their eligible dependents. Eligible dependents include the member's spouse and unmarried dependent children under age 23.

The GHLIT Major Medical coverage is not like coverage offered under group health plans where eligibility is based on employment. Instead, eligibility for GHLIT Major Medical coverage is based on membership in the AVMA, which is a non-employer "bona fide association." As a result, the GHLIT coverage is not considered an employment-related "group health plan" under the federal law ("HIPAA") that applies to medical insurance arrangements; the obligations for the GHLIT differ from those that apply to employer group health plans. This allows the GHLIT to make major medical coverage available exclusively to individual AVMA members and their families regardless of employment.

*Important Notice: The GHLIT Health Insurance Plans are not available to residents of Maine, Massachusetts, New Hampshire, New Jersey, North Dakota, Vermont and Washington. In addition, the GHLIT PPO, PPO Value and HSA Plans are not available in North Carolina.*

### What the health insurance plans cover

The plans provide coverage for a broad spectrum of Eligible Expenses incurred while insured, up to a \$5,000,000 maximum for benefits paid for each insured person for all such expenses he or she incurs while insured.

#### Eligible Expenses

- Hospital Room and Board charges up to the hospital's average daily rate for a semi-private room. (See exclusions & limitations.)
- Intensive or Cardiac Care Unit charges.
- Hospital charges for medical care and treatment (other than Room and Board) while an in-patient or out-patient.
- Physicians' charges for anesthesia (and its administration).
- Convalescent Nursing Home Room and Board charges up to 50% of the hospital's average daily Room and Board charge paid for the prior hospital confinement.
- Home Health Care charges, but only if the Nursing Home confinement begins, or the Home Health Care Plan is implemented, within 14 days after a hospital confinement of at least 3 days for the same cause. Home Health Care Plan Services include the following when furnished under a Home Health Care Plan: services of a home health aide; nursing care by a registered nurse; physical, occupation or speech therapy; laboratory services, medical supplies and services to the extent they would be Eligible Expenses if charges for them were incurred while a hospital in-patient.
- Physicians' and Surgeons' charges. (See exclusions and limitations.)
- X-ray or radioactive isotope therapy.
- Blood or blood derivatives and their administration.
- X-ray examinations and microscopic or laboratory tests and analysis.
- Anesthesia, oxygen and their administration.

- Casts, splints, braces, crutches, surgical dressings, and artificial limbs and eyes.
- Prescription drugs and medicines. (See exclusions and limitations.)
- Services of a physical therapist.
- Rental of wheelchair, hospital-type bed, iron lung or equipment for the administration of oxygen.
- Ambulance and transportation charges to the nearest hospital equipped to furnish required treatment.
- Services of a registered or licensed practical nurse. (See exclusions and limitations.)
- Charges for treatment of complications of pregnancy.
- Charge for one routine mammographic examination in a calendar year.
- Charges by a Chemical Dependency Treatment Facility (or Hospital) for treatment of alcoholism and drug abuse in accordance with a Treatment Plan. This includes charges for Room and Board while a resident in a Chemical Dependency Treatment Facility for up to \$250 per day and for no more than 60 days in a calendar year. Charges for out-patient medical and psychiatric treatment as part of a Treatment Plan are also included. *(Benefits for out-patient psychiatric treatment charges are payable at 50% and are limited to no more than \$50 per day.) (See exclusions and limitations.)*

### **Normal Pregnancies are covered**

Coverage is provided under the Traditional or HSA Qualified plans for eligible expenses incurred for a normal pregnancy, including delivery, as for any other condition. Eligible expenses for specified complications of pregnancy are also covered. These charges are subject to the deductible and co-insurance provisions. If insured under a PPO or PPO Value plan expenses are covered if you elect the Optional Maternity Benefits (as indicated on page 7 in the “Optional Maternity Benefits” section).

### **Well baby care is covered**

If the mother has coverage for her delivery charges as a member or a spouse, Eligible Expenses for her newborn baby will also be covered, subject to the child’s own deductible and co-insurance limits.

### **Well child care**

Children’s routine preventive care procedures are covered. For children under age 18, eligible child health supervision services will include 18 physicians’ visits at the following approximate age intervals: birth, 2, 4, 6, 9, 12, 15 and 18 months; and 2, 3, 4, 5, 6, 8, 10, 12, 14 and 16 years. The eligible expenses include those for physical examinations, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests.

The first \$300 of these charges incurred is subject to the deductible and co-insurance limits under Traditional plans C, D and X. If covered under one of the GHLIT PPO, PPO Value, Traditional Plan Y or HSA-Qualified plans the first \$300 of expenses incurred in a calendar year will be covered at 100% with no deductible. Expenses in excess of \$300 will be subject to the deductible and co-insurance provisions or any applicable co-pay for in-network office visits.

### **Adult physical exam benefit**

A routine adult physical examination benefit is included. Insureds age 18 or over may submit charges for a physical, routine immunizations (except those required for foreign travel), and x-ray or laboratory services ordered as part of the examination. These charges are subject to the deductible and co-insurance limits except if insured under one of the GHLIT PPO, PPO Value, Traditional Plan Y or HSA-Qualified plans. Under these plans, the first \$300 of expenses incurred in a calendar year will be covered at 100% with no deductible. Expenses in excess of \$300 will be subject to the deductible and co-insurance provisions.

### **Gynecological exam benefit**

An annual examination benefit makes certain charges eligible for reimbursement each calendar year. These include one gynecological examination, a PAP smear and x-ray or laboratory services given or ordered as part of the examination. These charges are subject to the deductible and co-insurance limits under Traditional plans C, D and X. If covered under one of the GHLIT PPO, PPO Value, HSA-Qualified plans or Traditional Plan Y these expenses can be counted towards the first \$300 of expenses incurred in a calendar year and will be covered at 100% with no deductible, as indicated above in the “Adult Physical Exam Benefit” section. Expenses in excess of \$300 will be subject to the deductible and co-insurance.

### **Eye exam benefits**

Charges for one routine eye exam, up to \$50 in a 24 month period, are covered under these plans. These charges are not subject to the plan deductible and co-insurance limits.

### Hospice Care benefit

This feature provides coverage for medical care and other services provided under a Hospice Program. Hospice programs address the special needs of the terminally ill with a life expectancy of 6 months or less and their families. They provide services which let the patient remain at home as long as possible, relieve pain and discomfort, and include help for family members coping with the patient's care and death. A description of the Hospice Benefit including covered services and benefit levels will be provided by the AVMA Group Health and Life Insurance Trust Office upon request.

### Exclusions and Limitations

No benefit is provided unless the expense is medically necessary and is incurred upon a physician's recommendation to treat an injury or sickness. **The fact that a doctor may prescribe, order, recommend or approve a service or supply does not automatically make the service or supply an Eligible Expense.** Moreover, the charge must be customary and reasonable as determined by New York Life and the person must incur it while insured and be legally obligated to pay it.

Eligible Medical Expenses do not include charges incurred in connection with:

- War or military service.
- Dental work, eyeglasses, hearing aids or cosmetic surgery (except for charges to treat an accidental injury when treatment begins within 90 days after the accident and the charges are incurred within 24 months after the accident).
- Hospitalizations when the covered person is admitted to the hospital on a Friday or Saturday unless the admission is due to an accident or emergency illness or if surgery is performed within 24 hours after the admission.
- Out-patient treatment for alcoholism or drug abuse except as provided under a Treatment Plan for alcoholism and drug abuse as indicated under Eligible Expenses.
- Hospital in-patient treatment for psychiatric conditions, drug abuse or alcoholism and out-patient physicians' charges for psychiatric services after a person has received combined benefits of \$25,000 for all such charges in the same calendar year.
- Out-patient physician's charges for psychiatric services in excess of \$100 for any one day of visits, nor aggregate charges for more than \$5,000 in the same calendar year. Moreover, the benefit percentage applied to such charges is always 50% so that the maximum benefit payable in the same calendar year is \$2,500.
- Private Duty Nursing after a person has received benefits of \$10,000 for such charges in the same calendar year.
- Experimental surgery or research charges.
- Custodial care.

- Any charges made by the insured or by his or her immediate family.
- Infertility Treatment Expenses – Expenses incurred for treatment of infertility will be excluded on any PPO or PPO Value plan where a maternity benefit has not been elected. In addition, infertility treatment expenses will be excluded from the HSA-Qualified Plans. On all other Major Medical plans that cover maternity expenses, we will cover expenses for infertility treatment subject to a maximum lifetime benefit of \$10,000, a 50% co-insurance provision (after the deductible is satisfied) and continue the current policy guidelines to determine whether the treatment is medically appropriate. (These expenses do not count towards satisfying the out-of-pocket maximum)
- Artificial insemination, In Vitro fertilization or any other method of artificial conception or implantation unless the insured has been unable to conceive after 12 months of unprotected sexual intercourse or is unable to sustain a successful pregnancy. (Refer to the certificate for certain treatment limitations and restrictions.)
- Sexual transformations.
- Immunizations required for travel.
- Radial keratotomy or surgery done in treatment of myopia.
- Health or check-up examinations in excess of one per year. (Except for children under age 18 as indicated in “Children’s Routine Preventive Care” section)
- Those losses for which benefits are payable by a worker’s compensation act or similar law.
- Hospital room and board charges for days determined to be not medically necessary.
- Routine nursery charges for a newborn dependent child unless the mother is insured as a member or spouse and her delivery charges are covered.
- Confinement in a Convalescent Nursing Home after the 120th day of any one period of confinement.
- Home Health Care Services by a home health aide, a registered nurse or a therapist, after an aggregate of 40 visits by all such specialists in the same calendar year.
- Gastric Bypass Limitations - Eligible expenses incurred for medically appropriate bariatric surgery are subject to the Plan Deductible and a 50% co-insurance provision. (These expenses do not count towards satisfying the out of pocket maximum.) In addition, to be considered eligible expenses under the policy, treatment must be provided by a certified First Health Center of Excellence for bariatric surgery and the GHLIT medical coverage must have been in force a minimum of 12 consecutive months on the insured. (You can request a listing of the First Health Centers of Excellence from the Trust Office)
- Home Health Care Services provided by anyone who is a relative of the insured or who usually lives in the same household.
- Some out-patient medications will be limited in the quantity to be dispensed. For example, you may be advised that your plan only covers ten pills in a 25 day period. If your prescription is written for more than the quantity allowed and you purchase the amount over the limitation, you will be responsible for the retail cost for the amount over the limited quantity and that cost will not be considered an eligible expense under your plan. You can request a listing of those drugs that are limited under the plan from the Trust Office.
- Pre-existing condition exclusion: Benefits will not be paid for an illness or injury due to a pre-existing condition as indicated below, until the end of 12 consecutive months during which the person has been insured under the plan. Pre-existing Condition means a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period immediately preceding the coverage effective date. However, the pre-existing condition exclusion will not apply if the applicant can prove that this coverage is replacing creditable coverage that was in force on him/herself or any other person applying for coverage for at least 18 months without a break in coverage of more than 63 days. A certificate of creditable coverage or some other satisfactory proof will be required as evidence that creditable coverage was in force. This certificate should be secured from the Plan Administrator of your current or last Health Plan.

### Pre-Admission Certification

To help ensure the appropriateness of treatment, necessity and length of hospital stays, **the plan requires Pre-Admission Certification if non-emergency hospitalization is recommended for the member or his or her insured dependent.**

Representatives of First Health, a company specializing in medical care coordination and management, evaluate all acute care medical admissions, and all admissions for the treatment of mental health and substance abuse, to help determine that your proposed inpatient treatment is necessary. This process will enable you to spend as much time as required in a health care facility but no longer than is necessary to allow you to get back to your family, work and personal responsibilities as quickly as possible.

In the event of an insured's emergency hospitalization, the case must be reviewed and certified within 24 hours of hospital admission to evaluate continued treatment.

*Insureds who fail to follow these procedures will be subject to a \$250 deductible for covered hospital expenses per hospital confinement. This out-of-pocket penalty is in addition to the insured's applicable deductible and will not count towards the "Stop Loss" maximum. Room and board charges will not be paid for hospital days determined to be not medically necessary.*

### Advance notification is required for a non-emergency admission

When your doctor recommends non-emergency (elective) treatment for you or a member of your family, you must notify a First Health representative seven to ten days before the scheduled admission. First Health will then review the recommendation to make sure that inpatient treatment is necessary. By gathering information about the illness, treatment plan, and proposed length of stay, First Health's medical review staff (all doctors and registered nurses) will base their recommendations on widely-accepted guidelines and criteria established by medical and government organizations. First Health will then notify you, your physician, and the hospital or mental health and substance abuse facility of the outcome of the evaluation.

The First Health medical review specialist will remain in contact with your doctor for the duration of the in-patient stay. If additional days in the treating facility are indicated, First Health will work with your doctor to certify these days, if appropriate. Any in-patient room and board charges for days that are determined by First Health to not be medically necessary will not qualify as eligible medical expenses under the plan. As a result, benefits for those charges will not be paid.

On Traditional Major Medical Plans, if you choose to receive treatment in a non-First Health Facility, your co-insurance reimbursement will be paid at a reduced level of benefit.

### Immediate notification is required for emergency admissions

If emergency acute care or mental health and substance abuse admissions is necessary for you or a covered member of your family, you, a family member, your doctor, or a representative from your treating facility must telephone the Trust Office at (800) 621-6360 and you will be connected to a First Health representative. Notification should be made immediately following admission or on the first business day following weekend or holiday admissions.

### Special maternity pre-admission service

If you are covered under the Traditional or HSA-Qualified Plans or have elected the Optional Maternity Benefit under the PPO or PPO Value Plans, you should pre-certify any obstetrical admission including pregnancy delivery for you or your covered dependent. You are asked to notify First Health during the first trimester. In addition to pre-certification, First Health provides a special maternity service to help identify a potential high-risk pregnancy and avoid premature birth. The time to discover complications is long before the mother arrives at the delivery room. This is the primary reason notification during the first trimester is so vital. Through the healthy maternity program, the expectant mother has access to a highly specialized service designed to promote early identification of potential risk factors during pregnancy and to emphasize prenatal care through educational material. When the expectant mother calls First Health to pre-certify her pregnancy, she will be asked a series of life-style and health-related questions to help ascertain whether potential risk factors exist. Once precertified, she will receive a complementary copy of America's pregnancy best seller, "What to Expect When You're Expecting." This service is not available if maternity is not covered.

### Preferred Medical Rates (10% discount)

As indicated in the 'When coverage becomes effective' section below, GHLIT medical coverage will be issued regardless of health status. However in an effort to attract more members to the GHLIT program, a new rate class has been developed for those members that would be considered a preferred risk. These new rates are 10% lower than the standard rates and are indicated in the proposed medical quote or rate chart. You will automatically be considered for the new discounted rates by completing the application. Members, spouses and dependent children will be considered for these rates. For dependent children to qualify for the preferred risk rate, all insured dependent children must be considered preferred risks.

### You can receive Preferred Provider Organization savings

In many parts of the country, discounted fees are offered by hospitals, physicians, and other medical care providers participating in a Preferred Provider Organization developed and managed by First Health. For a list of network participants in your area, visit AVMA GHLIT website, [www.avmaghlit.org](http://www.avmaghlit.org) or call the Trust Office at (800) 621-6360.

### All delivered by one of the leading national networks of health care providers

First Health specializes in medical care coordination and management, with experience in in-patient treatment of all medical situations. It is one of the largest directly contracted PPO networks in the United States.

- More than 4,500 hospitals, 438,000 physicians and other outpatient care providers nationwide.
- 90% of the entire US population has access to hospitals and doctors in The **First Health**® Network.
- The **First Health**® Network hospitals and physicians must meet and maintain rigorous quality standards.
- Network providers offer a full range of services including primary and specialty care, hospital-based services, freestanding surgery centers, radiology and pathology.

### Large Case management

The **First Health**® Network helps members and their families faced with catastrophic or chronic illness or injury. This voluntary program provides a nurse who will work with you and your doctor to see that you get the best, most appropriate treatment in the setting that is also convenient for you. Your case manager will assist you to:

- Plan every step of your medical treatment
- Help you make informed decisions by providing you with the information needed to determine the care plan for you and your family
- Coordinate all activities such as arranging home health care, home care equipment, and rehabilitation including physical therapy.

### When coverage becomes effective

Unless you have requested a special effective date, insurance will take effect on the first of the month following 30 days after the date of receipt of the application by the Trust Office provided the initial contribution is paid in a timely manner to the AVMA Group Health and Life Insurance Trust Office and you are eligible for coverage. Coverage will be issued regardless of health status; however, applicants will be medically underwritten for the premium rates they will be required to pay. An applicant could be required to pay up to and including 50% more than the standard rates (67% more

## COVERAGE DETAILS (CONTD)

than the preferred medical rates (see Preferred Medical Rates section) indicated in the proposed medical quote or rate chart). Do not send premium with your application. The applicant will be notified of the appropriate charges upon the completion of the review of the application. The applicant can decide at that point whether to take the AVMA GHLIT coverage.

### **Additional dependents may be automatically covered**

Coverage will be issued on eligible dependents regardless of health status. However, dependents will be medically underwritten for the premium rates the member will be required to pay for them. A member may be required to pay up to and including 50% more than the standard rates (67% more than the preferred rates indicated in the proposed medical quote or rate chart for dependents (spouse and/or children)).

### **However, there are two important exceptions.**

- When a member marries, the member's spouse and any additional eligible dependents acquired as a result of the marriage will be issued coverage under the Plan(s) in force for the member at the Standard Major Medical rates, if the application is received by the AVMA Group Health and Life Insurance Trust Office within 31 days. This coverage will be effective on the date the application is received by the Trust Office (provided the premium payment is received within 31 days of being billed).
- If a member is insured for dependent children coverage, up to three eligible children are covered automatically for the same coverages and no notice or additional payment is required. However, upon the birth or adoption/placement of a fourth eligible dependent child, the "newborn children" provision indicated below would apply. The fourth child would require an increase in the dependent child rate. Non-payment of the new dependent premium would result in termination of the dependent coverage.

### **Newborn children**

Automatic coverage also will be extended to a first child for the same coverage in force for the member at the standard rate. If both parents are insured as members, this child is eligible as a dependent of one parent only. The Trust Office must be given written notification of which parent will carry child coverage. Coverage will continue until the first regular billing date after the child is born, or for at least 31 days, if this is longer. If the member wishes to continue the coverage, he must notify the Trust Office in writing and remit the added payment within 31 days after the automatic coverage would normally terminate. The additional payment is due from the child's date of birth.

### **You will receive a separate Certificate**

Each insured member will receive a Certificate of Insurance evidencing coverage which is provided under Group Policy Form GMR.

### **Your benefits are coordinated with other plans you have**

If a person is covered by one or more group plans or any governmental plan or receives medical benefits under an auto insurance type plan, AVMA GHLIT benefits will be coordinated with these other plans so that he or she will not receive more than 100% of the total allowable expenses incurred.

**HSA ONLY:** Please note that if you or any of your dependents are covered under another health insurance program, it could affect your eligibility for a tax advantaged Health Savings Account (HSA). You should consult with your accountant or tax advisor to determine if you are eligible for a HSA.

## AVMA Medical Coverage for insureds age 65 and over

The AVMA GHLIT Medical plan you are insured under the day immediately preceding the attainment of age 65 can be continued by paying the applicable premium. The GHLIT benefits will be determined secondary to Medicare Parts A, B and D.

## When insurance ends

New York Life cannot terminate coverage or change benefits or premiums on an individual basis; it may do so only on a class-wide basis.

### AVMA GHLIT coverage ends when an insured:

- fails to pay insurance charges on time; or
- requests the coverage to end; or
- if the Master Policy terminates, provided replacement coverage is provided.

### Change in status:

If a member ceases to be an AVMA member, the insured's coverage will be automatically continued but his or her premium class will change. Premium rates for this class of insureds will be significantly higher than the AVMA GHLIT active member rates.

Also, the change in status applies to dependent coverage (1) for a spouse upon divorce; (2) for a dependent child when he or she becomes self-supporting, marries or reaches age 23 (In this case any coverage that is continued will be charged at the child's actual attained age.), (3) upon change in the member's premium class.

## There is continuation of Dependent Coverage

In the event of the member's death, dependents may continue their Medical Care coverage while eligible, until the spouse remarries.

Each insured person receives a **Certificate of Insurance** which describes his or her coverage in detail and describes some important terms. Here are a few of the more important definitions:

**Doctor Office Visit** means a charge by a doctor for an examination for diagnosis and treatment of an injury, sickness or pregnancy, an initial or confirmatory

consultation, diagnostic x-ray and lab services (except for high technology diagnostic procedures such as MRI, CAT scan or PET), diagnostic surgery, a routine\* wellness exam of a child (under age 20) and allergy injections. The preceding services must be provided in the doctor's office.

**Hospital** means an institution for the care and treatment of sick and injured persons. It must provide 24 hour nursing by graduate registered nurses and have organized facilities for diagnosis and surgery. But none of these qualify as a Hospital:

- An institution owned or run by national or state government (other than a facility of the United States Uniformed Services);
- An institution, or part of it, used mainly as a facility for rest, nursing, convalescing, the aged, or for remedial education or training.

**Home Health Agency** means a hospital, public agency or private non-profit organization, or a subdivision of such an entity, which primarily engages in providing skilled nursing service. It must be either licensed by the state or federally certified to participate in Medicare, as a Home Health Agency.

**Home Health Care Plan** means one which meets these standards:

- A physician must establish and approve the Plan in writing;
- The Plan must cover a condition which would otherwise require confinement in a Hospital or a Convalescent Nursing Home.

**Home Health Care Visit** refers to a visit by a member of a Home Health Care Team other than a home health aide and counts as one Home Health Care Visit. Four hours of service by a home health aide counts as one Home Health Care Visit.

**Convalescent Nursing Home** is an institution for skilled nursing care of sick and injured persons. It must meet these standards:

- It must be supervised 24 hours a day by a physician, registered nurse, or licensed practical nurse;

\*Based on Preventive Health Coverage Guidelines determined by New York Life

## DEFINITION OF TERMS

- It must have a physician's services available at all times;
- It must have enough nurses to give continuous patient care;
- It must keep a daily medical record for each patient.

**Hospice** means a public agency or private organization that provides a coordinated plan of home, outpatient and inpatient care for a terminally ill person and emotional support and bereavement services for the family. It must:

- Provide care by a team of trained medical personnel and counselors acting under an independent hospice administration;
- Meet all the licensing requirements of the state in which it operates;
- Be accredited by the Joint Commission on Accreditation of Hospitals if a hospital-based Hospice.



## IMPORTANT NOTICE

### How New York Life Underwrites Your Request for AVMA Coverage

Information regarding insurability will be treated as confidential. In considering your request for standard or preferred rates, we will rely on the medical information you provide, and on the information you authorize us to obtain from your doctor, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, Inc. (Medical Information Bureau). New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. New York Life may use or disclose information as described in the HIPAA Notice of Privacy Practices in Protected Health Information. We may make a brief report to MIB; however, we will not disclose our underwriting decision. Information in our files may be seen by New York Life and Plan Administrator employees, but only on a "need to know" basis in considering your request. Upon receipt of all requested information we will make a determination as to whether your request for coverage can be approved for standard rates.

MIB is a nonprofit, membership organization of life insurance companies that operates an information exchange on behalf of its members. When you apply for insurance or submit a claim for benefits to a MIB member company, medical or non-medical information may be given to the Bureau, which may then be furnished to member companies.

If we cannot provide the coverage you requested, we will tell you why. If you feel our information is inaccurate, you will be given a chance to correct or complete the information in our files. Upon written request to New York Life or MIB, you will be provided with non-medical information, generally medical information will be given either directly to the proposed insured or to a medical professional designated by the proposed insured. Your request is handled in accordance with the Fair Credit Reporting Act Procedures. If you question the accuracy of

the information provided by MIB, you may contact MIB and seek a correction. MIB's information office is P.O. Box 105, Essex Station, Boston, MA 02112. For Canadian residents, the address is 330 University Avenue, Suite 403, Toronto, Canada M5G 1R7. MIB can be reached toll free in the U.S.A and Canada at 866-692-6901. For hearing impaired, TTY 866-346-3642.

**For NM Residents,** PROTECTED PERSONS (1) have a right of access to certain CONFIDENTIAL ABUSE INFORMATION (2) we maintain our files and they may choose to receive such information directly. You have the right to register as a PROTECTED PERSON by sending a signed request to the Administrator at the address listed on the application. Please include your full name, date of birth and address.

(1) PROTECTED PERSON means a victim of domestic abuse who has notified us that he/she is or has been a victim of domestic abuse; and who is an insured or prospective insured.

(2) CONFIDENTIAL ABUSE INFORMATION means information about: acts of domestic abuse of abuse status; the work or home address or telephone number of a victim of domestic abuse; or the status of an applicant or insured as family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship.

If we can provide the coverage you requested, we will inform you as to when such coverage will be effective. Under no circumstances will coverage be effective prior to this date. Payment of a premium contribution with your application does not mean that there is any insurance in force before the effective date as determined by New York Life.

NEW YORK LIFE INSURANCE COMPANY



**Broker/Administrator:**  
HealthPlan Services  
3501 Frontage Road  
Tampa, FL 33607

**Underwritten by:**  
New York Life Insurance Co.  
51 Madison Ave.  
New York, NY 10010

**Claims Administrator:**  
Harrington Benefit Services  
55 E. Jackson Blvd., 7th Floor  
Chicago, IL 60604

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A Membership Service of the American Veterinary Medical Association

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