

AVMA GHLIT Medical Plans

***For current medical
insureds age 64 only***

**Designed by veterinarians
for veterinarians**



Insurance you can trust.

Underwritten by New York Life Insurance Company (NY, NY 10010)

Medical Plans

WE'VE GOT YOU COVERED

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.

Nine Trustees, all AVMA Members, and one AVMA Liaison Trustee, 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.

New York Life Insurance Company (NY, NY 10010), the underwriter, has received the highest possible ratings for financial strength from some of the insurance industry's leading independent rating services including Moody's Investor Service (AAA), Standard & Poor's (AAA), Fitch Ratings (AAA), and A.M. Best (A++).*

*Individual Third Party Ratings Reports (as of 7/7/10)

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.

Some Important Benefits of the PPO Plans

Convenience

We've teamed up with the UnitedHealthcare Options PPO Network, a leading national network, 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 healthcare provider is always yours. The plan pays benefits both in and out of the network.

No Primary Care Referrals Required

Unlike many managed healthcare 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 UnitedHealthcare Options PPO 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.

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 out-patient 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 gastric bypass surgery, infertility treatment, and the treatment of psychiatric conditions, drug abuse and alcoholism treatment, however, are limited as explained in the Exclusions and Limitations section of this brochure. These 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

	PLATINUM PLAN		GOLD PLAN		BRONZE PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible						
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	Unlimited		Unlimited		Unlimited	
Prescription Drugs	In-Network Pharmacy[†] \$15 co-pay for generic (up to 30-day supply) \$25 co-pay for preferred brands (up to 30-day supply) \$35 co-pay for other brand name drugs (up to 30-day supply) Mail order available for 2x co-pay (up to 90-day supply)			Out-of-Network Pharmacy Deductible & Co-insurance		

**Based on eligible expenses incurred in calendar year.

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

[†]If you purchase a brand-name drug when a generic drug equivalent can be substituted you will be responsible for paying your brand-name drug co-pay plus the difference in cost between the brand-name and generic equivalent.

For a list of UnitedHealthcare Options PPO Network providers in your area, visit www.avmaghlit.org or call 1.800.621.6360.

AVMA GHLIT PPO VALUE PLANS

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 UnitedHealthcare Options PPO 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, L and R***, an office visit to a physician in the UnitedHealthcare Options PPO 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 (up to 30-day supply);
- \$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 out-patient prescription drugs will be subject to the out-of-network deductible and co-insurance limits. See coverage details for limitations.

*Eligible expenses for gastric bypass surgery, infertility treatment, and the treatment of psychiatric conditions, drug abuse and alcoholism treatment, however, are limited as explained in the Exclusions and Limitations section of this brochure. These 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, special deductibles and any eligible expenses that are paid at 100%, are not included for purposes of reaching the co-insurance "stop-loss maximum".

**Based on eligible expenses received in calendar year.

***Effective May 1, 2011.

PPO Value Plans

	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
Deductible										
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*										
Individual	To \$10,000 After Deductible		To \$10,000 After Deductible		To \$10,000 After Deductible		To \$10,000 After Deductible		To \$10,000 After Deductible	
Family	To \$30,000 After Deductible		To \$30,000 After Deductible		To \$30,000 After Deductible		To \$30,000 After Deductible		To \$30,000 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 or \$35 co-pay per visit		Deductible & Co-insurance	
Hospitalization**	Deductible & Co-insurance		Deductible & Co-insurance		Deductible & Co-insurance		Deductible & Co-insurance		Deductible & 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 Out-Patient (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	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
Prescription Drugs	In-Network Pharmacy*** \$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)						Out-of-Network Pharmacy Deductible & Co-insurance			

*Based on eligible expenses received in calendar year.

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

***If you purchase a brand-name drug when a generic drug equivalent can be substituted you will be responsible for paying your brand-name drug co-pay and applicable co-insurance plus the difference in cost between the brand-name and generic equivalent.

For a list of UnitedHealthcare Options PPO Network providers in your area, visit www.avmaghlit.org or call 1.800.621.6360.

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

Family Deductibles

A Plan V family deductible will be considered satisfied in a calendar year when the amount of eligible expenses for all insured family members totals \$6,000.

A family member insured on Plan V as part of a Family coverage, will also be considered as satisfying an embedded individual deductible of \$3,000 when that insured family member incurs eligible medical expenses in a given calendar year of \$3,000. Any eligible expenses incurred that calendar year in excess of the deductible will be applied to satisfy the family deductible. For Plan V, the embedded individual deductible is \$3,000. 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 (does not apply to Plan V):

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[†]

The plans are designed so that the maximum out-of-pocket expenses you pay each year are limited. Here's how they work:

For Plan V once an individual deductible has been satisfied the plan pays 80% (70% if hospitalized in an out-of-network hospital) of eligible expenses for that calendar year until the insured individual has incurred \$4,500 of out-of-pocket expenses including the individual deductible. Then additional eligible expenses incurred in a calendar year are paid at 100%.

Once a family deductible has been satisfied, the plan pays 80% (70% for an out-of-network hospitalization) of eligible expenses for that calendar year until family members have incurred a total of \$9,000 of out-of-pocket expenses including the family deductible. Additional eligible family expenses for that calendar year will be covered at 100%.

For Plans C, D, X and Y 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. 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.

[†]See Exclusions and Limitations for additional details on reaching the stop-loss limit.

Traditional Major Medical Plans

	PLAN C	PLAN D	PLAN X	PLAN V	PLAN Y
Deductible Individual	\$500	\$750	\$1,500	\$3,000	\$5,000
Family	\$1,500	\$2,250	\$3,000	\$6,000	\$10,000
Co-Insurance Levels¹	80/20	80/20	80/20	80/20	80/20
Co-Insurance Stop-Loss Limit² Individual	To \$5,000 ³ After Deductible	To \$5,000 ³ After Deductible	To \$5,000 ³ After Deductible	\$1,500 ² After Deductible	To \$5,000 ³ After Deductible
Family	To \$10,000 ³ After Deductible	To \$10,000 ³ After Deductible	To \$10,000 ³ After Deductible	\$3,000 ² After Deductible	To \$10,000 ³ After Deductible
Doctor Office Visit	Deductible & Co-insurance	Deductible & Co-insurance	Deductible & Co-insurance	Deductible & Co-insurance	Deductible & Co-insurance
Hospitalization^{1,4}	Deductible & Co-insurance	Deductible & Co-insurance	Deductible & Co-insurance	Deductible & Co-insurance	Deductible & Co-insurance
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Prescription Drugs Deductible	\$200	\$300			
Reimbursement Generic	80%	80%			
Reimbursement Preferred	70%	70%	Deductible & Co-insurance	Deductible & Co-insurance	Deductible & Co-insurance
Reimbursement Brand	60%	60%			
Co-Insurance 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.

¹Co-insurance 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. (except Plan V)

²Based on out-of-pocket eligible expenses paid by the insured(s) in calendar year.

³Based on eligible expenses incurred by the insured(s) in calendar year.

⁴Subject to an additional \$250 deductible if hospitalization is not pre-certified.

For a list of UnitedHealthcare Options PPO Network providers in your area, visit www.avmaghlit.org or call 1.800.621.6360.

COVERAGE DETAILS

Most AVMA members are eligible to apply

Regular AVMA GHLIT members turning age 65, and who are residents of the United States, may apply to insure themselves and their eligible dependents. Eligible dependents include the member's spouse/domestic partner and dependent children under age 26. (Domestic partners should contact the Trust office for the necessary forms and directions for applying for domestic partner coverage).

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, with no dollar maximum for essential 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.
- Home Healthcare charges, but only if the Nursing Home confinement begins, or the Home Healthcare Plan is implemented, within 14 days after a hospital confinement of at least 3 days for the same cause. Home Healthcare Plan Services include the following when furnished under a Home Healthcare 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.
- Charges for treatment of complications of pregnancy.
- Charge for one routine mammographic examination in a calendar year.
- Hospital in-patient treatment for psychiatric conditions, drug abuse or alcoholism and out-patient physicians' charges for psychiatric services. The benefit percentage applied to out-patient physicians' charges for psychiatric services is always 50%.
- Hospital in-patient treatment for charges by a Chemical Dependency Treatment Facility (or Hospital) for treatment of alcoholism and drug abuse in accordance with a Treatment Plan and out-patient physicians' charges for psychiatric services. This includes charges for Room and Board while a resident in a Chemical Dependency Treatment Facility for no more than 60 days in a calendar year. Charges for out-patient medical and psychiatric treatment as part of a Treatment Plan and out-patient physicians' charges for psychiatric services are also included. *(Benefits for out-patient psychiatric treatment charges are payable at 50%). (See exclusions and limitations).*

Normal pregnancies are covered

Coverage is provided under all GHLIT 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.

Preventive Services Coverage

The following services are covered without regard to any deductible, co-payment, or co-insurance requirement that would otherwise apply:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation for the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
- With respect to Covered Persons who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

For more information on items and services that are covered, you may go to www.healthcare.gov/law/about/provisions/services/lists.html on the internet.

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.

COVERAGE DETAILS (CONTD)

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.
- 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 from Traditional Plan V. On all other Major Medical plans, 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.
- 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/domestic partner and her delivery charges are covered.
- Confinement in a Convalescent Nursing Home after the 120th day of any one period of confinement.
- Home Healthcare 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. (Except for Traditional Plan V, these expenses do not count towards satisfying the out-of-pocket maximum). In addition, to be considered eligible expenses under the policy, the GHLIT medical coverage must have been in force a minimum of 12 consecutive months on the insured.
- Home Healthcare 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 to eligible dependent children under age 26 or 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.

COVERAGE DETAILS (CONTD)

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 UMR, Inc., a company specializing in healthcare 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 in-patient treatment is necessary. This process will enable you to spend as much time as required in a healthcare 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 UMR representative seven to ten days before the scheduled admission. UMR will then review the recommendation to make sure that in-patient treatment is necessary. By gathering information about the illness, treatment plan, and proposed length of stay, UMR medical review staff (all doctors and licensed nurses) will base their recommendations on widely-accepted guidelines and criteria established by medical and government organizations. UMR will then notify you, your physician, and the hospital or mental health and substance abuse facility of the outcome of the evaluation.

The UMR 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, UMR will work with your doctor to certify these days, if appropriate. Any in-patient room and board charges for days that are determined by UMR 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-UnitedHealthcare Options PPO Network 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 1.800.621.6360 and you will be connected to a UMR representative. Notification should be made immediately following admission or on the first business day following weekend or holiday admissions.

Special maternity pre-admission service

You should pre-certify any obstetrical admission including pregnancy delivery for you or your covered dependent. You are asked to notify UMR during the first trimester. In addition to pre-certification, UMR 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 UMR 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 pre-certified, she will receive educational material and support throughout the pregnancy. Educational focus includes preparing low-risk and at-risk mothers with early warning signs and appropriate courses of action. Other areas of focus include prenatal care, pregnancy safety tips, exercising, nutrition and common complaints.

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 UnitedHealthcare Options PPO Network. For a list of network participants in your area, visit the AVMA GHLIT website, www.avmaghlit.org or call the Trust Office at 1.800.621.6360.

All delivered by one of the leading national networks of healthcare providers

The UnitedHealthcare Options PPO Network is a broad nationwide network that will provide coverage to AVMA GHLIT insureds – even during travel away from home.

- More than 5,000 hospitals, 600,000 physicians and ancillary service providers nationwide.
- UnitedHealthcare Options PPO Network hospitals and physicians must meet and maintain rigorous quality standards.

Large Case management

UMR provides case management to assist members in making informed healthcare decisions. Case management is a voluntary program designed to support the member and the member's family as well as help coordinate details surrounding complex healthcare needs. Members who benefit from this program include those with a potentially long term, high cost or catastrophic illness or injury. The case manager will work with the member and their family in maximizing their available benefits including the most appropriate cost effective setting for treatment, acting as a liaison with the member's healthcare team of providers and providing recommendations for community resources.

When coverage becomes effective

The AVMA GHLIT is offering you a special enrollment opportunity to change your AVMA GHLIT Major Medical plan, prior to reaching age 65. Medical underwriting is not required should you wish to lower your deductible. If you choose to take advantage of this offer, your change in coverage will become effective on the first of the month immediately preceding your 65th birthday. Please note that any changes you may elect will not automatically apply to a spouse/domestic partner and/or dependents on your policy. They may remain on their existing plan or you may choose to have your spouse/domestic partner and/or dependents switch to your new plan at the same time you do. If you elect to change your plan but keep your spouse/domestic partner and/or dependents on their existing plan, you will need to indicate this. If this is the case, you will be assigned a new case number and, as a result, you will receive a separate bill for your spouse/domestic partner and/or dependents. While we recognize that the increase in the cost of premium to move all insured participants to a lower deductible may not be economically feasible at this time, we would like to make sure you are aware of this option.

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 for dependents, spouse/domestic partner and/or children.

COVERAGE DETAILS (CONTD)

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 G-14884/Face 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.

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.

DEFINITION OF TERMS

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. An example of "class" can be a group of insureds with the same age or gender.

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 can 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 or termination of domestic partnership; (2) for a dependent child when he or she becomes self-supporting or reaches age 26 (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 Healthcare 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 Healthcare Visit refers to a visit by a member of a Home Healthcare Team other than a home health aide and counts as one Home Healthcare Visit. Four hours of service by a home health aide counts as one Home Healthcare Visit.

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

DEFINITION OF TERMS (CONTD)

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;
- 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, out-patient and in-patient 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.

NOTES

IMPORTANT NOTICE

How New York Life Underwrites Your Request for AVMA GHLIT 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. (formerly known as 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 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 you with standard rates, 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:

MIB, Inc.
50 Braintree Hill Park
Suite 500
Braintree, MA 02184-8734

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 at 866-692-6901. For hearing impaired, TTY 866-346-3642. Canadian residents can call 416-597-0590. Information for consumers about MIB may be obtained on its website www.MIB.com.

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
Rev 1/09

This material briefly describes the provisions of Master Policy G-14884/Face policy form GMR issued to the Trustees of the AVMA GHLIT. For complete details on your coverage please see your Certificate of Insurance.



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

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

Claims Administrator:
UMR, Inc.
233 N. Michigan Ave., Ste. 1050
Chicago, IL 60601

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A Membership Service of the American Veterinary Medical Association

The AVMA Group Health and Life Insurance Trust • 3501 Frontage Road • Tampa, FL 33607 • 1.800.621.6360