

# ***AVMA GHLIT Medical Plans***

**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.

### **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.

### **Traditional Major Medical Plans**

These plans provide generous benefit coverage and the freedom to choose any doctor. Deductible options range from \$3,000 to \$5,000, with very reasonable out-of-pocket stop-loss maximums, regardless of the providers chosen. In addition, the \$3,000 deductible Plan V is HSA-Qualified.

### **Some Important Benefits of the PPO Plans**

#### **Convenience**

We've teamed up with the United HealthCare 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 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 United HealthCare 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, 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

	BRONZE PLAN	
	In-Network	Out-of-Network
<b>Deductible</b>		
Individual	\$1,000	\$1,500
Family	\$3,000	\$4,500
<b>Co-Insurance Levels</b>	80/20	60/40
<b>Doctor Office Visit</b>	\$20 co-pay per visit	Deductible & Co-insurance
<b>Co-Insurance Limits**</b>	\$5,000 after Deductible	\$5,000 after Deductible
<b>Hospitalization***</b>	Deductible & Co-insurance	Deductible & Co-insurance
<b>Lifetime Maximum</b>	Unlimited	Unlimited
<b>Prescription Drugs</b>	<b>In-Network Pharmacy<sup>†</sup></b> \$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)	<b>Out-of-Network Pharmacy</b> Deductible & Co-insurance

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

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

<sup>†</sup>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 United HealthCare Options PPO Network providers in your area, visit [www.avmaghlit.org](http://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 two 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 \$1,000 (in-network) or \$1,500 (out-of-network) to as high as \$2,500 (in-network) or \$3,750 (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 United HealthCare 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 Plan L and Plan R\*\*\*, an office visit to a physician in the United HealthCare 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 out-patient 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 L		PLAN R	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Deductible</b>				
Individual	\$1,000	\$1,500	\$2,500	\$3,750
Family	\$3,000	\$4,500	\$7,500	\$11,250
<b>Co-Insurance Levels</b>	80/20	60/40	80/20	60/40
<b>Co-Insurance Limits*</b>				
Individual	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
<b>Doctor Office Visit</b>	\$35 co-pay per visit	Deductible & Co-insurance	Deductible & Co-insurance or \$35 co-pay per visit†	Deductible & Co-insurance
<b>Hospitalization**</b>	Deductible & Co-insurance	Deductible & Co-insurance	Deductible & Co-insurance	Deductible & Co-insurance
<b>Additional Deductible</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Out-Patient Surgical</b> (per procedure)	\$250	\$500	\$250	\$500
<b>CT Scan/MRI</b> <b>Out-Patient</b> (per procedure)	\$250	\$500	\$250	\$500
<b>ER (per visit)</b> Waived if admitted	\$250	\$250	\$250	\$250
<b>Lifetime Maximum</b>	Unlimited	Unlimited	Unlimited	Unlimited
<b>Prescription Drugs</b>	<b><u>In-Network Pharmacy***</u></b> \$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)		<b><u>Out-of-Network Pharmacy</u></b> 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.

†Effective May 1, 2011.

For a list of United HealthCare Options PPO Network providers in your area, visit [www.avmaghlit.org](http://www.avmaghlit.org) or call 1.800.621.6360.

# 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 20% 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 minimum deductibles which are set by the IRS.

### **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 the single IRS maximum no matter what the health plan deductible amount is.

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 catch-up contributions.

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 may 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 20% 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, or if you are in a domestic partnership; 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, and resident of the United States, you may apply to insure yourself, your spouse/domestic partner, and dependent children under age 26. Underwritten by New York Life and approved by the AVMA GHLIT, these high-deductible health insurance plans offer medical coverage 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 Plans

### Individual Deductible

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. Please refer to the table to find out how benefits are paid in and out-of-network after the individual deductible has been satisfied. The Individual Deductible Plans are only available to members.

### Family Deductible

#### ***Plan S1 (\$3,000 Family Deductible):***

Under this Family Deductible Plan, 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/domestic partner and member and children and member, spouse/domestic partner and children. The Individual Deductible does not apply under the Family Deductible Plan.

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.

#### ***Plans S2 (\$5,200 Family Deductible), S3 (\$7,000 Family Deductible) and S4 (\$10,000 Family Deductible):***

A Family member insured on a High Deductible/HSA-Qualified S2, S3 or S4 Major Medical Plan as part of a Family coverage, will have satisfied an embedded individual deductible when that insured family member incurs eligible medical expenses in a given calendar year that exceed the individual deductible limits established for that calendar year. At that point, any co-insurance paid by that individual will contribute towards the unsatisfied portion of the Family Deductible. For High Deductible/HSA-Qualified S2 plans, the embedded individual deductible is \$2,600; for High Deductible/HSA-Qualified S3 plans, the embedded individual deductible is \$3,500; and for High Deductible/HSA-Qualified S4 plans, the embedded individual deductible is \$5,000.

Please see descriptions of Traditional Plan V which is also a HSA-Qualified plan.

**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

	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
<b>Deductible</b>								
Individual	\$1,500		\$2,600		\$3,500		\$5,000	
Family	\$3,000		\$5,200		\$7,000		\$10,000	
<b>Co-Insurance Levels</b>								
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%
<b>Out-of-Pocket Limits*</b>								
Individual	\$5,000 Including Deductible	\$7,500 Including Deductible	\$5,000 Including Deductible	\$7,500 Including Deductible	\$5,000 Including Deductible	\$7,500 Including Deductible	N/A Including Deductible	\$7,500 Including Deductible
Family	\$10,000 Including Deductible	\$15,000 Including Deductible	\$10,000 Including Deductible	\$15,000 Including Deductible	\$10,000 Including Deductible	\$15,000 Including Deductible	N/A Including Deductible	\$15,000 Including Deductible
<b>Lifetime Maximum</b>	Unlimited		Unlimited		Unlimited		Unlimited	
<b>Prescription Drugs</b>	Deductible & 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.

For a list of United HealthCare Options PPO Network providers in your area, visit [www.avmaghlit.org](http://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 two levels, \$3,000 or \$5,000 per year for individual coverage.

### 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.

A Plan Y family deductible 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 for Plan Y only:

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 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 Plan 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.

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

## Traditional Major Medical Plans

	PLAN V	PLAN Y
<b>Deductible</b>		
Individual	\$3,000	\$5,000
Family	\$6,000	\$10,000
<b>Co-Insurance Levels<sup>1</sup></b>	80/20	80/20
<b>Co-Insurance Stop-loss Limit<sup>2</sup></b>		
Individual	\$1,500 <sup>2</sup> after Deductible	To \$5,000 <sup>3</sup> after Deductible
Family	\$3,000 <sup>2</sup> after Deductible	To \$10,000 <sup>3</sup> after Deductible
<b>Doctor Office Visit</b>	Deductible & Co-insurance	Deductible & Co-insurance
<b>Hospitalization<sup>1,4</sup></b>	Deductible & Co-insurance	Deductible & Co-insurance
<b>Lifetime Maximum</b>	Unlimited	Unlimited
<b>Prescription Drugs</b>	Deductible & Co-insurance	Deductible & Co-insurance

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

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

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

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

**For a list of United HealthCare Options PPO Network providers in your area, visit [www.avmaghlit.org](http://www.avmaghlit.org) or call 1.800.621.6360.**

## COVERAGE DETAILS

### Most AVMA members are eligible to apply

Regular AVMA members under 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 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.
- 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 conditions 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 <http://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 and the HSA-Qualified Plans. 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 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. (Except for Traditional Plan V and HSA-Qualified plans, 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 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.
- 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 health 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 in-patient 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 UMR, Inc. 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-United HealthCare 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.

### **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 rates are 10% lower than the standard rates. You will automatically be considered for the new discounted rates by completing the application. Members, spouses/domestic partners 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 United HealthCare Options PPO Network. For a list of network participants in your area, visit the AVMA GHLIT website, [www.avmaghlit.org](http://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 United HealthCare 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.
- United HealthCare 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 health care 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 health care 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 health care team of providers and providing recommendations for community resources.

### **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 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.

## COVERAGE DETAILS (CONTD)

### **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.

### **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.

## DEFINITION OF TERMS

**HSA ONLY:** Please note that if you or any of your dependents are covered under another health insurance program, or if you are in a domestic partnership; 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 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\* preventive 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.

\*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.



## 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](http://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

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