

STUDENT PPO PROGRAM AND STUDENT LIFE & DISABILITY INSURANCE

Available Exclusively to SAVMA Members
Designed by Veterinarians for Veterinarians

Underwritten by New York Life Insurance Company

PROTECT YOUR MOST IMPORTANT ASSET—YOUR HEALTH

The PPO Medical Plan For SAVMA Members

Quality health insurance is one of the most important purchases anyone can make. Without it, even less severe illness or injury can devastate a family's financial security. That is why this Student PPO Plan has been designed to be truly affordable for student members and their families, thanks to the group purchasing power of AVMA members across the country.

No Primary Care Referrals... You Go Straight To Any Network Physician And Specialist Whenever You Wish

Unlike many managed care healthcare plans such as HMOs, you are free to go to any doctor or specialist without first receiving a referral from a specified primary care physician. And, while this coverage can pay benefits even if you go outside of the United HealthCare Options PPO Network, the benefits, savings and convenience are greatest when you choose network providers.

Most SAVMA Members Are Eligible To Apply

SAVMA members who are residents of the United States and under age 65 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 student members and their families regardless of employment.

State Restrictions: This GHLIT Student PPO Plan is not available to residents of Maine, Massachusetts, New Hampshire, New Jersey, North Carolina, North Dakota, Vermont, and Washington.

The Protection Of The GHLIT Group Major Medical Plan, With...

Lowest Available Deductible—\$250

Our Student Preferred Provider Option (PPO) Plan offers you our lowest deductible option.

Unlimited Lifetime Maximum

This PPO plan provides coverage with no dollar maximum for eligible medical expenses incurred while insured under the AVMA GHLIT Group Policy for each insured person.

Low \$20 Doctor's Office Visit Co-Pay

Whenever you visit a network physician or specialist, all you pay is \$20 for the office visit charge.

Large Case Management

UMR, Inc. 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.

PLUS... An Affordable Rate For You, Your Spouse/Domestic Partner And Eligible Children—Regardless Of Age! *(See the "Enrollment" section of this brochure for charges.)*

And, 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 are subject to rigorous quality standards.

You Get Greater Savings And Convenience With Network Providers

While this GHLIT PPO Plan pays benefits for services outside of the United HealthCare Options PPO Network, you will enjoy the greater savings and convenience this Plan offers when you use Network providers.

For a list of Network participants in your area, visit the AVMA GHLIT website: www.avmaghlit.org or call: 1.800.621.6360.

This Affordable Plan Gives You Our LOWEST Deductible For You And Your Family!

Calendar Year Deductibles:

Per person in-network..... \$250

Per family in-network..... \$750

Per person out-of-network \$750

Per family out-of-network..... \$2,250

About Your Individual & Family Deductibles...

The cash deductibles are liberalized 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 the year the accident happened and the next year.

Emergency Room Deductible

There is an additional deductible of \$75 for each Emergency Room (ER) visit. Expenses for that visit in excess of this deductible could be subject to the applicable in-network or out-of-network deductible and co-insurance limits. If the ER visit results in a hospitalization, the additional deductible will be covered for that visit.

Important “Stop Loss” Co-Insurance Protection

Co-Insurance: after the deductible has been satisfied, the plan pays 80%* of the next \$10,000 of eligible expenses incurred through the United HealthCare Options PPO Network (or 60%* if incurred outside the United HealthCare Options PPO Network) and 100%* of further eligible expenses incurred in that calendar year.

** Eligible expenses for gastric bypass surgery 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, deductibles and any eligible expenses that are paid at 100% are not included for purposes of reaching the co-insurance “stop-loss” maximum.*

PPO Plan Co-Pay Amounts

Doctor Office Visits Co-pays:

\$20 co-pay per visit

If your physician is a participant in the United HealthCare Options PPO Network, charges for a doctor office visit will be limited to \$20 co-pays per visit. These co-pays will not count towards satisfying your deductible and will not be applied to your co-insurance maximum. Doctor office visits with non-network physicians will be subject to the out-of-network deductible and the out-of-network co-insurance provisions.

Prescription Drug Co-Pays (up to 30 day supply):

- \$10 co-pay for generic (level one)**
- \$25 co-pay for preferred brands (level two)**
- \$50 co-pay for other brand name drugs (level three)**

Mail Order Drug Co-Pays (up to 90 day supply):

- \$20 co-pay for generic (level one)**
- \$50 co-pay for preferred brands (level two)**
- \$100 co-pay for other brand name drugs (level three)**

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.

If you present your prescription drug ID card to a pharmacy that participates in the Medco network, each prescription will be subject to a co-pay of either \$10 (\$20 for mail order) for each generic drug; \$25 (\$50 for mail order) for each preferred brand name drug; and \$50 (\$100 for mail order) for all other eligible brand name drugs. The prescription drug co-pays are not applied to the calendar year deductible or the co-insurance "stop-loss" maximums. 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 60% co-insurance limits. Please refer to your AVMA GHLIT Prescription Drug brochure for more details.

NON-COVERED OR LIMITED MEDICATIONS

Some out-patient medications are not covered by your plan. If you are advised that your drug is not covered, you will be required to pay the full retail price and those charges will not be considered an eligible expense under the plan. Other 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 excluded and limited under the plan from the Trust Office.

Your Plan Includes...

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.

Rabies Titer Benefit

This benefit is included especially for veterinary students. This coverage will pay up to the first \$35 for the cost of a rabies titer while insured on the Student PPO Plan. Any expenses for rabies titers in excess of \$35 will be subject to the plan's deductible and co-insurance limits. Expenses for rabies prophylaxis are subject to the plan's deductible and co-insurance limits.

Eye Exam Benefits

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

Hospice Care

Charges for medical care and other services for the patient and family provided under a Hospice Program for terminal illness with a life expectancy of six months or less. (A more detailed description of the covered hospice benefit services and benefit levels are provided by the AVMA Group Health and Life Insurance Trust Office upon request.)

What This Student PPO Program Covers

The PPO medical plan for SAVMA members provides 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 under this AVMA GHLIT Group Policy.

Eligible Expenses Include:

- Hospital Room and Board charges up to the hospital's average daily rate for a semi-private room. *(See exclusions and limitations section.)*
- 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 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. When furnished under a Home Healthcare Plan, Home Healthcare Plan Services include: home health aide services; nursing care by a registered nurse; physical, occupational 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 section.)*
- X-ray or radioactive isotope therapy.
- Blood or blood derivatives and their administration.
- X-ray examinations and microscopic or laboratory tests and analyses.
- Anesthesia, oxygen and their administration.
- Casts, splints, braces, crutches, surgical dressings, and artificial limbs and eyes.
- Prescription drugs and medicines. *(See exclusions and limitations section.)*
- 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.

- Charge for one routine mammographic examination in a calendar year.
- Normal pregnancy, including delivery.
- Complications of Childbirth—charges for surgery and related medical care required for caesarean section, extra-uterine pregnancy, complications requiring intra-abdominal surgery after termination of pregnancy, and pernicious vomiting or toxemia and convulsions while hospitalized.
- Newborn Infant Care—medical charges before an infant is discharged from the hospital in which he or she was born, will be covered if a parent is insured.
- 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 percent.)

(See exclusions and limitations section.)

Please Note These 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:

- Hospital room and board charges for days determined to be not medically necessary.

- War or military service.
- Dental work, eye examinations (except as provided under Eligible Expenses), eyeglasses, radial keratotomy or surgery done in the treatment of myopia, 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.
- Certain out-patient prescription drugs.
- Experimental surgery or research charges.
- Custodial care.
- Any charges made by the insured or by his or her immediate family.
- Artificial insemination, in vitro fertilization or any other method of artificial conception or implantation.
- Sexual transformations.
- Immunizations required for travel.
- Those losses for which benefits are payable by a worker's compensation act or similar law.
- 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 without a prior hospitalization or after the 120th day of any one period of confinement.
- Gastric Bypass Limitations—Eligible expenses incurred for medically appropriate bariatric surgery are subject to the Plan Deductible and a 50% co-insurance provision. (These expenses do not count towards satisfying the out of pocket maximum.) In addition, to be considered eligible expenses under the policy, GHLIT medical coverage must have been in force a minimum of 12 consecutive months on the insured.

- 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.
- Home Healthcare Services provided by anyone who is a relative of the insured or who usually lives in the same household.
- 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.

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. Creditable coverage is coverage provided under a health plan or government health plan. (Hospital indemnity coverage does not qualify as creditable coverage.) A certificate of creditable coverage or some other satisfactory proof will be required as evidence that creditable coverage was in force. This certificate should be secured from the Plan Administrator of your current or last Health Plan.

Pre-Admission Certification

Follow These Procedures To Avoid A Financial Penalty

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 is 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.

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's medical review staff—all doctors and registered nurses will base their recommendations on widely-accepted guidelines and criteria established by medical and government organizations. 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 provider 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.

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 Administration Office at **1.800.621.6360**, and you will be connected to a UMR, Inc. representative. **Notification should be made immediately following admission or on the first business day following weekend or holiday admissions.**

Insureds who fail to abide by the above 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.

Additional Important Features

When Coverage Becomes Effective

Your insurance will take effect on the first of the month following 30 days after the date of receipt of your application by the Trust Office provided the initial contribution is paid 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 50% more than the PPO rates indicated in this brochure. **Do not send premium with your application.** You 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 Student PPO coverage.

Additional Dependents May Be Automatically Covered

Coverage will be issued on eligible dependents regardless of health status. However, dependents will be medically underwritten for the premium rates the member will be required to pay for them. A member may be required to pay up to 50% more than the PPO rates indicated in this brochure for dependents, spouse/domestic partner and/or children. However, there are two important exceptions:

1. When a member marries, his/her 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 Basic 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.)

2. If a member is insured for dependent children coverage, additional eligible children are covered automatically for the same coverages and no notice or additional payment is required.

Automatic Coverage will also be extended to a first child for the same coverage in force for the member at the Basic rate. If both parents are insured as members, this child is eligible as a dependent of one parent only. Simply notify the Trust Office in writing as to 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 you wish to continue the coverage, 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 first of the month coincident with or following the child's date of birth.

Coordination Of Benefits With Other Plans You Have

If a person is covered by one or more other 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.

About Continuation Of Insurance

The coverage is underwritten by New York Life. 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.

When Coverage Ends

As long as you remain a SAVMA member and a full-time veterinary student, the Master Policy remains in force, and your premiums are paid in a timely manner, your Student PPO coverage will continue protecting you until the earlier of the date you elect the guaranteed graduate student member offer or at the end of the month in which you graduate. Of course, you may cancel in writing at any time.

New York Life has agreed not to exercise its right to terminate the Master Policy as long as: 1) AVMA continues to sponsor only the New York Life Program and 2) participation in the plan exceeds 10,000 insured members.

Change In Status

If a student ceases to be a SAVMA member, the insured's medical coverage can be automatically continued under the \$500 deductible (Plan C) Traditional GHLIT Plan 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 or SAVMA PPO rates.

Also, the change in status applies to dependent coverage (1) for a spouse upon divorce or termination of a 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 may be certain circumstances where an insured person may be eligible to continue coverage for limited periods after it would otherwise be subject to the "Change in Status" provision as explained above (e.g., a spouse after divorce, a member after his or her membership ends, for example.) Contact the Trust Office immediately upon the occurrence of an event which you know will cause your insurance to change.

Continuation Of Dependent Coverage

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

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.

DEFINITIONS OF IMPORTANT TERMS

Each insured member receives a Certificate of Insurance that 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 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.

These **DO NOT** 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 that 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. Also, four hours of service by a home health aide counts as one Home Healthcare Visit.

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

- It must be supervised 24 hours a day by a physician, registered nurse, or licensed practical nurse;
- 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 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 1/09 ed.

IMPORTANT INSURANCE PROTECTION WHILE YOU'RE IN SCHOOL—FOR LESS THAN 50 CENTS A DAY!

The Student Life & Disability Package Exclusively for SAVMA Members

This package offers many benefits:

- \$500-A-Month Disability Income Protection
- \$100,000 of Group Term Life Insurance
- Easy Enrollment & Quick Processing

Why It's So Important To You Right Now

Regardless of age, thousands of veterinary students across America share the need for essential financial protection—against unexpected disability or even death.

Even as a student, you may have substantial financial obligations beyond your education expenses, school loans and normal living expenses. And, like many students, you may also be providing for a home and family. If something happens to you, who will cover your expenses? Who will repay your school loans? Who will provide for your family?

Disability Coverage Is A Must

Your ability to earn income is your most valuable asset—both now and as a practicing professional later on. A disabling injury or illness can strike anyone at any age and deprive you of that asset. Whether you're earning income now or not, if an accident or illness suddenly disables you, you could be temporarily—or for an extended period of time—unable to earn enough to cover your bills, attend your classes or, ultimately continue on into your profession as you've planned.

With no income, you could still have to pay all of your normal living expenses, disability-related expenses and, ultimately, any loans you may have. That's why disability income insurance is perhaps the most important protection you can have—both now and throughout your career.

The Student Life & Disability Package Provides \$500-A-Month Disability Income Protection

- \$500 monthly benefits begin after 30 days of continuous total disability covered by this Plan if you are unable to attend veterinary school classes full-time.
- Benefits paid for up to 5 full years—the maximum benefit period is five years provided you remain disabled during this period.

- Up to \$2,000 Special Semester Benefit—as much as four monthly benefits will be paid if a covered injury, illness or pregnancy result in you missing two consecutive weeks of veterinary school classes and as a result you are required to withdraw from your veterinary school for the balance of that academic year. This benefit may be paid only one time while you're covered under this Plan.
- Terminal Benefit of \$500 is paid if you die while receiving total disability benefits from this Plan.

And, Life Insurance Is Just As Crucial

While it may be difficult to think about life insurance when you're just starting out, now is the best time!

The cost of life insurance coverage is less when you are young. Plus, future health changes could make it difficult or even impossible for you to get or afford the amount of life insurance you'll need as your financial responsibilities increase with your age.

The Student Life & Disability Package Provides \$100,000 Group Term Life Insurance

\$100,000 Tax-Free Death Benefit is paid to any beneficiary you choose—tax free—to help cover your outstanding debts, final expenses and cushion the financial hardship your untimely death could cause your family.

Quick Processing... No Medical Underwriting

If you are a Student AVMA (SAVMA) member (at least age 18 but under age 65) and a full-time veterinary student (and not on active duty in the armed forces) you are eligible for coverage with no medical exam or health history required.

IMPORTANT PROTECTION FEATURES

Premiums Waived While Disabled

If you become "disabled" before age 65 and remain so for six months, the AVMA Group Health and Life Insurance Trust will pay further premiums to continue your Student Life & Disability Insurance coverages in force when that disability began. Premiums will be paid by the Trust while you stay so disabled, and until coverage would otherwise terminate due to age or until you have reached the end of your maximum benefit period for Disability Income Coverage.

When Your Coverage Becomes Effective

Insurance will take effect on the date your enrollment form is received by the Trust Office provided the initial contribution is paid to the AVMA GHLIT Office within 31 days of that date, and you are performing the normal activities of a person in good health of like age on the date your enrollment form is received.

When Coverage Ends

As long as you remain a SAVMA member and a full-time veterinary student, the Master Policy remains in force, and your premiums are paid in a timely manner, your coverage will continue protecting you until the earlier of the date you elect the guaranteed graduate student member offer or the May 1 of the year you graduate or your attainment of age 65. Of course, you may cancel in writing at any time.

New York Life has agreed not to exercise its right to terminate the Master Policy as long as: 1) AVMA continues to sponsor only the New York Life Program and 2) participation in the plan exceeds 10,000 insured members.

(See exclusions, limitations and important definitions you should know.)

And, When You Graduate—

The GHLIT Offers You Our Guaranteed Graduate Offer

You have up to 31 days after you graduate to convert your Student Life & Disability coverage without providing medical evidence of your good health. You'll be able to convert your Student Life & Disability coverage through your GHLIT School Agent to the GHLIT Graduate Special Offer.

- \$100,000 of affordable AVMA GHLIT Group Term Life Insurance with coverage for your spouse/domestic partner and dependent children available, too.
- \$2,000-A-Month AVMA GHLIT Long-Term Disability Income Coverage with a Cost of Living Adjustment option and an "Own Occupation" option, under the Basic Protection Package which also includes \$25,000 AD&D Decreasing Term Life and Rabies Prophylaxis Benefits which pays up to \$600.

IMPORTANT PLAN DEFINITIONS FOR DISABILITY INCOME INSURANCE

Disability means an accidental bodily injury or sickness that disables you so that you are unable to perform the responsibilities or duties of a veterinarian student. Consecutive days of disability must be used to satisfy the waiting period. Throughout the disability you must be under a doctor's care, other than yourself, and not working at a gainful occupation.

Successive Disabilities are treated as if they were the same one unless they are separated by at least 90 days of full-time work.

Presumed Disability means you will be presumed to be disabled if you sustain an accidental bodily injury while insured which caused the loss of: both feet; the sight of both eyes; or use of both hands. If you incur a covered total disability due to an illness which caused the total and permanent loss of: use of two limbs; the sight of both eyes; speech; or hearing in both ears.

Loss of Feet means they are completely severed through or above the ankle joint. Loss of sight or use of hands means total and permanent loss that cannot be remedied by surgery or other means.

Pre-Existing Condition means any condition for which a person consults a doctor, receives medical services or supplies or takes any medication during the six-month period prior to the effective date of coverage. It does not include any condition after the person has been continuously insured under the Policy for six months.

Semester means the academic year as defined by the SAVMA member's respective veterinary school.

EXCLUSIONS AND LIMITATIONS

Life Insurance benefits will be limited to a refund of contributions paid if death results from suicide, attempted suicide, or an intentionally self-inflicted injury (while sane or insane) within the first two years of coverage. (Missouri Residents: Benefits will not be paid for death resulting from suicide within the first two years if New York Life can show that suicide was intended at the time of application.)

Disability Income Insurance benefits are not payable for disability resulting from: service in the military, naval or airforce of any country, alliance or international organization (or civilian unit serving such force); commission of a felony and/or incarceration; pre-existing conditions for the first six months of coverage (see Definitions), pregnancy, childbirth or a related medical condition (except for specified complications of pregnancy and the "Special Semester Benefit"); self-inflicted injuries* (whether intentional or while insane); war (declared or undeclared), act of war, or armed conflict involving the armed forces of one or more countries. Benefits are not paid for the first 30 days of a covered disability or any period of disability which does not require the regular care of a doctor (unless no longer required for prudent medical management or for a covered total disability which causes total and permanent loss of the use of two limbs, sight of both eyes, speech, or hearing in both ears.)

**Missouri Residents: The exclusion for disabilities due to self-inflicted injuries is not applicable to injuries caused by an attempted suicide while insane.*

THE AVMA GHLIT TRUST SEAL— YOUR ASSURANCE OF QUALITY, VALUE, SERVICE AND ATTENTION TO YOUR SPECIFIC NEEDS

The AVMA Group Health & Life Insurance Trust has provided members like you with quality coverage, value and service you can count on. AVMA members are more than just program participants... members are in charge.

Nine Trustees, all AVMA Members, and one AVMA Liaison Trustee, supervise the Program and its professional operating staff, and provide overall direction. In addition, the Trustees act as a Review Board should a member ever experience a problem with the insurance program. It's your "Board of Trustees" that gives a member's perspective to an issue.

These plans are designed to save you money on important protection. And, they are truly affordable for SAVMA members, thanks to the combined group purchasing power of thousands of SAVMA and AVMA members across the country.

ENROLL NOW—IT COULDN'T BE EASIER

Student PPO

Below are the current monthly premium rates with effective dates of May 1, 2011 and later for the Student PPO plan:

Student Member	\$174.00*
Spouse/Domestic Partner	\$174.00*
Child(ren)	\$161.00*

When enrolling, do not send premium with your application. You will be notified of the appropriate charges upon the completion of the review of the application. You can decide at that point whether to take the AVMA GHLIT Student PPO coverage.

Student Life & Disability

The current monthly premium for the Student Life & Disability package is \$13.75.* Premium payments are due once every six months, so you won't have to worry about missing a payment date every month.

To enroll in the Student PPO plan and/or Student Life & Disability package, complete, sign and return the enrollment form to the AVMA GHLIT Trust Office in the enclosed reply envelope.

Once insured, you'll receive your Certificate of Insurance and your bill. Certificate of Insurance is provided under Group Policy G-14884/Face policy form GMR.

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

This Valuable AVMA GHLIT Group Protection Is Underwritten By New York Life Insurance Company.

As one of America's top insurance companies, New York Life has helped seven generations of families achieve their financial goals. They have a long history and heritage of financial strength and integrity... and a strong commitment to serving AVMA Members' insurance needs.

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++).*

QUESTIONS ABOUT THESE PLANS?

Consult your GHLIT Campus Representative, or call toll-free for immediate assistance: **1.800.621.6360**

Or visit us online: www.avmaghlit.org

If you prefer, write to:

**The AVMA Group Health
and Life Insurance Trust Office
3501 Frontage Road
Tampa, FL 33607**

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

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

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

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

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

www.avmaghlit.org

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.