

# Student PPO Program

AVMA | GHLIT



Group Health & Life  
Insurance Trust Programs

*Ready for anything?*

*Protect your most important  
asset—your health.*

**Designed  
by Veterinarians  
for Veterinarians**

Valuable Benefits.  
Remarkable Service.

**Student PPO Program**

*Customized Health Insurance  
Exclusively for SAVMA Members*

## 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 thousands of members across the country.

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

Unlike many managed care health care 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 pays benefits even if you go outside of The **First Health**® Network, the benefits, savings and convenience are greatest when you choose network providers.

### ***Most SAVMA Members Are Eligible To Apply.***

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

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

**State Restrictions:** This GHLIT PPO Plan is not available to residents of Maine, Massachusetts, New Hampshire, New Jersey, North Carolina, North Dakota, Vermont, and Washington. See the Rate Chart and the "When Coverage Becomes Effective" section of the brochure for charges.

**Exclusively FOR Student  
AVMA Members!**

## **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.

***\$5 Million Maximum***

This PPO plan provides coverage for up to \$5 million of 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***

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

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

***PLUS... An Affordable Rate For You,  
Your Spouse And Eligible Children —  
Regardless Of Age!***

## And, All Delivered By One Of The Leading National Networks Of Health Care Providers

First Health specializes in medical care coordination and management of all medical conditions for both in-patient and out-patient levels of care. It is **one of the largest** directly contracted PPO networks in the United States —

- More than 4,224 hospitals, 412,165 physicians and other outpatient care providers nationwide.
- 90% of the entire U.S. population has access to hospitals and doctors in The **First Health**® Network.
- The **First Health**® Network hospitals and physicians are subject to rigorous quality standards.
- Network providers offer a full range of services including primary and specialty care, hospital-based services, freestanding surgery centers, radiology and pathology.

### You Get Greater Savings And Convenience With Network Providers

While this GHLIT PPO Plan pays benefits for services outside of The **First Health**® 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](http://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.

### ***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 **First Health**® Network (or 60%\* if incurred outside The **First Health**® Network) and 100%\* of further eligible expenses incurred in that calendar year.

\*Eligible expenses for nursing care, 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 (with the exception of nursing care expenses) and any additional deductibles that may be imposed if a hospital stay is not approved in the Pre-Admission Certification process, as well as any co-pays and any eligible expenses that are paid at 100% are not included for purposes of reaching the co-insurance “stop-loss” maximum.

## PPO Plan Co-Pay Amounts

### ***Doctor Office Visits Co-pays:***

\$20 co-pay per visit.

If your physician is a participant in The **First Health**® 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:***

\$15 co-pay for generic (level one)  
\$25 co-pay for preferred brands (level two)  
\$35 co-pay for other brand name drugs (level three).

### ***Mail Order Drug Co-Pays:***

\$30 co-pay for generic (level one)  
\$50 co-pay for preferred (level two)  
\$70 co-pay for other brand name drugs (level three).

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 \$15 (\$30 for mail order) for each generic drug; \$25 (\$50 for mail order) for each preferred brand name drug; and \$35 (\$70 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 co-insurance limits. Please refer to your AVMA GHLIT Prescription Drug brochure for more details.

***Out-patient Prescription Drug Benefits are limited to \$1,000 per calendar year (in or out-of-network).***

## **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 ...**

### ***Physical Exam Benefits***

Charges for a routine adult physical exam are included. Insureds age 18 or over may submit charges for a physical, including X-ray or laboratory services ordered as part of the exam and routine immunizations (except for foreign travel).

### ***Gynecologic Benefits***

Charges for one annual gynecologic exam, Pap smear, and X-ray or laboratory services given or ordered as part of the examination are included.

### ***Children's Routine Preventive Care Benefits***

Eligible Expenses for physical exams, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests for children under age 18 are covered. This includes 18 physician visits at these approximate age intervals: birth, 2, 4, 6, 9, 12, 15 and 18 months; then, 2, 3, 4, 5, 6, 8, 10, 12, 14 and 16 years of age.

*All of the previous benefits are subject to the applicable 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 with 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, up to a \$5,000,000 maximum 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.)
- 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 up to 50 percent of the hospital's average daily Room and Board charge paid for the prior hospital confinement.
- Home Health Care charges . . . but only if the Nursing Home confinement begins, or the Home Health Care Plan is implemented, within 14 days after a hospital confinement of at least 3 days for the same cause. When furnished under a Home Health Care Plan, Home

Health Care 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. (See exclusions and limitations section.)
- Charge for one routine mammographic examination in a calendar year.
- 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, other than well-baby care, will be covered if a parent is insured.

- Student PPO Program
- Charges by a Chemical Dependency Treatment Facility (or Hospital) for treatment of alcoholism and drug abuse in accordance with a Treatment Plan, including charges for Room and Board while a resident in a Chemical Dependency Treatment Facility for up to \$250 per day and for no more than 60 days in a calendar year. Charges for out-patient medical and psychiatric treatment as part of a Treatment Plan are also included. (Benefits for out-patient psychiatric treatment charges are payable at 50 percent and are limited to no more than \$50 per day.) (See exclusions and limitations.)

***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.
- Hospital in-patient treatment for psychiatric conditions, drug abuse or alcoholism and out-patient physician's charges for psychiatric services after a person has received combined benefits of \$25,000 for all such charges in the same calendar year.
- Out-patient physician's charges for psychiatric services in excess of \$100 for any one day of visits, nor aggregate charges for more than \$5,000 in the same calendar year. Moreover, the benefit percentage applied to such charges is always 50 percent so that the maximum benefit payable in the same calendar year is \$2,500.
- Private Duty Nursing after a person has received benefits of \$10,000 for such charges in the same calendar year.
- Out-patient prescription drugs after a person has received \$1,000 for such charges in a calendar year.
- Certain out-patient prescription drugs as indicated in the AVMA GHLIT Prescription Drug brochure.
- 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.
- Health or check-up examinations in excess of one per year. (Except for children under age 18 as indicated in “Children’s Routine Preventive Care” section.)
- Those losses for which benefits are payable by a worker’s compensation act or similar law.
- Pregnancy except certain complications of pregnancy such as indicated under Eligible Expenses.
- Routine nursery charges for a newborn dependent child.
- 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, treatment must be provided by a certified First Health Center of Excellence for bariatric surgery and the GHLIT medical coverage must have been in force a minimum of 12 consecutive months on the insured. (You can request a listing of the First Health Centers of Excellence from the Trust office).
- Home Health Care Services 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 Health Care 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***

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 the pre-existing condition exclusion will not apply. 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

***You need to 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 First Health, a company specializing in medical care coordination and management, evaluate all acute care medical admissions, and all admissions for the treatment of mental health and substance abuse, to help determine that your proposed in-patient treatment is necessary. This process will enable you to spend as much time as is 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.***

***Advance notification is required for a non-emergency admission.***

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

The First Health medical review specialist will remain in contact with your provider for the duration of the in-patient stay. If additional days in the treating facility are indicated, First Health will work with your doctor to certify these days, if appropriate.

Any in-patient room and board charges for days that are determined by First Health to not be medically necessary will not qualify as eligible medical expenses under the plan. As a result, benefits for those charges will not be paid.

***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 First Health representative.

**Notification should be made immediately following admission or on the first business day following weekend or holiday admissions.**

**Insured's 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 the rate chart. **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 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 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 the August 1 of the year 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 will 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; (2) for a dependent child when he or she becomes self-supporting, marries or reaches age 23 (In this case, any coverage that is continued will be charged at the child's actual attained age.) (3) upon change in the member's premium class.

There 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, etc). 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 remarries.

**You will receive a separate certificate.**

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

**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 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 that 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. Also, four hours of service by a home health aide counts as one Home Health Care Visit.

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

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

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

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

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

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

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

(1) PROTECTED PERSON means a victim of domestic abuse who has notified us that he/she is or has been a victim of domestic abuse; and who is an insured or prospective insured. (2) CONFIDENTIAL ABUSE INFORMATION means information about: acts of domestic abuse of abuse status; the work or home address or telephone number of a victim of domestic abuse; or the status of an applicant or insured as family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship. If we can provide the coverage you requested, we will inform you as to when such coverage will be effective. Under no circumstances will coverage be effective prior to this date. Payment of a premium contribution with your application does not mean that there is any insurance in force before the effective date as determined by New York Life.

NEW YORK LIFE INSURANCE COMPANY 4/03 ed.

## **We Are Here To Serve You!**

- Contact Your School Agent.
- Call the Trust Office Toll-Free:  
**1-800-621-6360**
- Visit: **[www.avmaghlit.org](http://www.avmaghlit.org)**

# AVMA GHLIT



Group Health & Life  
Insurance Trust Programs

## **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. And this Plan is no exception. That's because AVMA members are more than just program participants . . . members are in charge.

Ten Trustees, all AVMA members, 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.

This Health Insurance option is designed to save you money on important protection. And, it is truly affordable for SAVMA members, thanks to the combined group purchasing power of thousands of SAVMA and AVMA members across the country.

AVMA GHLIT Trust Office  
Attention Enrollment Services  
P.O. Box 30481  
Tampa, FL 33630-3481

## **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.

### **Questions About This Plan?**

Consult Your GHLIT Campus Representative, Or Call Toll-Free for Immediate Assistance:

**800-621-6360**

Or visit us online:

**[www.avmaghlit.org](http://www.avmaghlit.org)**

If you prefer, write to:

#### **The AVMA Group Health and Life Insurance Trust Office**

3501 Frontage Road  
Tampa, FL 33607



A Membership Service of the American Veterinary  
Medical Association

#### **Underwritten by:**

New York Life Insurance Company  
(New York, New York 10010)

#### **Broker/Administrator:**

HealthPlan Services

#### **Claims Administrator:**

Harrington Benefit Services