

Value Health Plan

*Sickness & Accident, Hospital/Surgery
For Individuals, Families and Groups*

NO DEDUCTIBLE OR CO-PAYS

USE ANY HOSPITAL OR DOCTOR

HOSPITAL BENEFIT TO \$1,000 PER DAY

INTENSIVE CARE TO \$4,000 PER DAY

SURGERY BENEFIT TO \$20,000

ANESTHESIOLOGIST BENEFIT TO \$4,000

BENEFITS PAID DIRECTLY TO YOU

ISSUE AGES 0 TO 64

VALUE HEALTH PLAN

Sickness & Accident, Hospital/Surgery

MEDICAL BENEFITS SCHEDULE

HOSPITAL BENEFITS					
BENEFIT DESCRIPTION	DEDUCTIBLE	CLASSIC MAXIMUM BENEFIT	SILVER MAXIMUM BENEFIT	GOLD MAXIMUM BENEFIT	PLATINUM MAXIMUM BENEFIT
Daily hospital confinement from the 1st day up to 1 year per hospital confinement due to sickness or injury	NONE	\$250.00	\$500.00	\$750.00	\$1,000.00
Daily intensive care INCLUDES hospital confinement benefit up to 30 days per sickness and accident	NONE	\$1,000.00	\$2,000.00	\$3,000.00	\$4,000.00
SURGICAL BENEFITS					
Pays scheduled amount for surgery due to sickness or injury	NONE	\$5,000.00	\$10,000.00	\$15,000.00	\$20,000.00
Pays schedule expenses for administration of anesthesia during a covered surgery	NONE	\$1,000.00	\$2,000.00	\$3,000.00	\$4,000.00
EMERGENCY BENEFITS					
Pays expenses incurred for emergency treatment due to an injury	NONE	\$62.50	\$125.00	\$187.50	\$250.00
Pays expenses incurred for ambulance services due to sickness or injury	NONE	\$125.00	\$250.00	\$375.00	\$500.00

ISSUE AGE UNISEX RATES				
AGE	MONTHLY CLASSIC	MONTHLY SILVER	MONTHLY GOLD	MONTHLY PLATINUM
CHILD	\$10.00	\$20.00	\$30.00	\$40.00
19-39	\$20.00	\$40.00	\$60.00	\$80.00
40-49	\$25.00	\$50.00	\$75.00	\$100.00
50-59	\$37.50	\$75.00	\$112.50	\$150.00
60-64	\$45.00	\$90.00	\$135.00	\$180.00

Add \$15.00 monthly administration fee per certificate.

This brochure is a brief summary of benefits only and is subject to the terms, conditions, exclusions and limitations of Group Policy No. G-610,090, Form No. G-19000. Coverage may vary or may not be available in all states.

Q & A

Do rates go up due to age increase? No

Who is eligible for coverage?

Any eligible individuals under age 65 and their dependents who are VBA Members.

Who are eligible dependents?

Your spouse under age 65 and your dependent children under the age of 19 or under the age of 25 if they are a full time student.

What are the medical requirements to enroll in the plan?

Simply answer a few “yes/no” questions on the application form. There is no medical exam required. Issuance of a Certificate of Insurance or payment of benefits may depend upon the answers given in the application and the truthfulness thereof.

Do I have to pay deductibles and co-pays under this plan?

No, this plan is designed to pay the first dollar of covered expenses for the member and all the member’s enrolled dependents up to the limits of the plan option selected.



When does coverage begin?

Coverage will begin on the first of the month following approval of the application and receipt of the first modal premium.

Can I use any doctor or hospital?

Yes, you may use any doctor or hospital of your choice.

Are pre-existing conditions covered?

After your policy has been in effect for more than 12 months, pre-existing conditions are covered

What is a pre-existing condition?

Any condition you have now or had within a 12 month period prior to the effective date of coverage for each insured person



For VBA Members

**Value
Benefits**
of America, Inc. (VBA)
A Not-For-Profit Association

Exclusions and Limitations

PRE-EXISTING CONDITIONS PROVISIONS FOR MEDICAL CARE BENEFITS

PRE-EXISTING CONDITION means an injury or sickness for which a person: incurred charges received medical treatment consulted a physician, or took prescribed drugs within 12 months before he became insured under a given benefit section of the group policy. In spite of any other provision of the group policy: No benefits will be paid under a benefit section for charges incurred for a pre-existing condition **until:**

1. the person has not: incurred charges received medical treatment consulted a physician, or taken prescribed drugs for such condition, or any complication of it, for 12 continuous months, while insured; or
2. the person stays insured under such benefit section for 12 continuous months.

GENERAL EXCLUSIONS

No medical care benefits will be paid by the group policy for charges incurred for treatment which:

1. is given after a person's insurance ends, regardless of when the injury or sickness occurred. However, medical care benefits may be provided in the Benefits After Insurance Ends provision of a given benefit section.
2. is not essential for the necessary care or treatment of the injury or sickness involved.

NECESSARY CARE OR TREATMENT means that a treatment, service, supply, or medicine: is appropriate and essential for the diagnosis or treatment of the person's symptoms; is within the scope, duration or intensity of that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; is furnished within the framework of generally accepted methods of medical treatment; involves only the use of any drugs or substances formally approved by the United States Food and Drug Administration.

A treatment, service, supply or medicine will **not** be considered NECESSARY CARE OR TREATMENT if it is: part of a treatment plan that is determined to be an Experimental Procedure or for research purposes; or provided primarily as a convenience to the patient, the patient's family or the provider of care.

EXPERIMENTAL PROCEDURE means any medical procedure, equipment, treatment or course of treatment, or drugs or medicines that are: limited to research; not proven in an objective manner to have therapeutic value or benefit; restricted to use by medical facilities capable of carrying out scientific studies; of questionable medical effectiveness; or would be considered inappropriate medical treatment.

To determine whether a procedure is experimental, United States Life will consider, among other things, commissioned studies, opinions and references to or by the American Medical Association, the Federal Food and Drug Administration, the Department of Health and Human Services, the National Institutes of Health, the Council of Medical Specialty Societies and any other association or program or agency that has the authority to review or regulate medical testing or treatment.

3. would be given free of charge if the person was not insured.

However, medical care benefits **will be paid** for covered charges incurred by a state for medical assistance to an insured person under Title XIX of the Social Security Act of 1965.

4. results from a war or an act of war.
5. results from intentionally self-inflicted injury.
6. Is given by a person's spouse or his or his spouse's parents, children, grandparents, grandchildren, sisters, brothers, aunts, uncles, nieces or nephews.

The policy described in this brochure provides limited benefits only, which are less than the minimum standards for benefits for major medical expenses coverage as prescribed by the insurance regulatory authority of your state.

Be sure to review your certificate completely when you receive it.

MAIL APPLICATIONS TO:
Value Benefits of America
 15575 N. 79th Pl – #100
 Scottsdale, AZ 85260
 800-366-2467

Administrator:
GEM Administrators
 919 N. 1st St
 Phoenix, AZ 85004
 800-756-4906

The United States Life Insurance Company in the City of New York

A member company of American International Group, Inc.

FOR HOSPITAL CONFINEMENT INDEMNITY COVERAGE UNDER GROUP POLICY FORM G-19000.

Policy Holder:		Value Benefits of America						
Applicant:	Date of Birth:	Place of Birth:	Age:	Sex:	Ht	Wt	Social Security Number:	
Home Address: (Include number & street, city, state and zip code)				Mailing or Billing Address (if other than Home Address)				
Home Phone:	Work Phone:	Email Address:			Occupation:			

DEPENDENT COVERAGE: I wish to apply for coverage for my following dependents:

First, Middle and Last Name	Date of Birth	Age	Sex	Ht	Wt	Social Security No.	Relationship

BENEFITS BEING APPLIED FOR:

	(check one)	<input type="checkbox"/> Classic	<input type="checkbox"/> Silver	<input type="checkbox"/> Gold	<input type="checkbox"/> Platinum
Daily Hospital Confinement Benefits.....	\$250	\$500	\$750	\$1,000	
Daily Intensive Care/Coronary Care Unit Confinement Benefits.....	\$1,000	\$2,000	\$3,000	\$4,000	
Maximum Emergency Accident Treatment Benefits.....	\$62.50	\$125	\$187.50	\$250	
Maximum Ambulance Transportation Benefits.....	\$125	\$250	\$375	\$500	
Maximum Surgical Benefits Per Schedule.....	\$5,000	\$10,000	\$15,000	\$20,000	

QUALIFYING MEDICAL QUESTIONS:

- In the past 24 months, have you or your dependents, if applying for insurance, had chest pains, disease or disorder of the heart, liver, kidneys or lungs, high blood pressure, albumin or sugar in the urine, diabetes, cancer, tumors or ulcers?..... Yes No
- Have you or your dependents, if applying for insurance, during the past 24 months, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution? Yes No
- Please give details to any "Yes" answers, specifying person, condition, dates, treatment received and/or recommended and current status:

 _____ (Attach additional signed & dated sheet if more room needed.)

OTHER COVERAGE:

- Are you now covered under, or awaiting issuance of, any accident or health insurance?..... Yes No
 If "Yes", please list ALL accident and health coverages now in force or pending issuance (include coverage name and form number (if known), coverage type and benefit amount, and company name: _____
 _____ (Attach additional signed & dated sheet if more room needed)
Please note: This coverage is not meant to be a replacement for comprehensive benefits under a health insurance plan or health maintenance organization (HMO) plan and this is not a comprehensive plan.
- Will any existing coverage be replaced by the coverage you are applying for?..... Yes No
 If "Yes", please give company name, type of coverage and policy number: _____

PREMIUM:

Insurance Premium \$ _____ plus \$15.00 Monthly Administrative Fee
 Payment Mode: Monthly Bank Draft Monthly List Bill (2 or more) Semi-Annual Annual

I HEREBY APPLY for coverage as indicated on this Application. I have read or had read to me the completed application. To the best of my knowledge and belief, the answers to the questions contained in this application are true and complete.

I UNDERSTAND AND AGREE that: (1) this coverage will be granted solely and entirely in reliance upon my answers to the questions contained in this application; (2) no coverage will exist until a Certificate of Coverage is issued, and will be in force only as of the Certificate Effective Date; (3) any misstatement of fact in this application may result in the denial of benefits or cause the Company to change or rescind my coverage; (4) any loss for a condition for which medical advice or treatment was received from a doctor during a twelve month period prior to the date of this application, will not be covered until my coverage has been in force for 12 months.

WARNING: Any person who, with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

Dated at _____ this _____ day of _____, 20 _____

Signature of Applicant: **X** _____ date signed _____

I hereby certify that I personally saw the applicant and truly and accurately recorded the above information.

Agent's Signature: **X** _____ date signed _____

Print Agent's Name Bill Howell Agent's Number(s) 76954

**VALUE BENEFITS OF AMERICA CLASSIC
MEMBERSHIP ENROLLMENT FORM***

Print Primary Member Name: _____

I agree to the Value Benefits of America terms and conditions as listed on this form.

X _____
Signature of Primary Member Date Signed

About Value Benefits of America Classic Membership:

Classic Benefits include over 400 major chains on-line in over 50 shopping categories, including everything from major department stores to specialty retailers to boutiques. In addition to earning rewards up to 25% shopping at participating on-line merchants, you can also receive point of sale discounts up to 50% from leading national retailers. Point of sale discounts are available on brand name merchandise, travel services and entertainment, including savings on movie tickets, movie rentals and at theme parks nationwide. You'll also enjoy savings of up to 60% dining at fine restaurants nationwide with discounted dining certificates, and the savings don't stop there. Included at no charge are discounts at over 55,000 pharmacies for your prescription drugs as well as lab tests and x-ray imaging services. Complete details of membership benefits are provided at www.VBAmembers.com.

*Classic Membership does not include Accident Medical, Emergency Air Ambulance or Accidental Death & Dismemberment Benefits.

**BANK DRAFT AUTHORIZATION AGREEMENT FOR
AUTOMATIC MONTHLY PAYMENTS**

I hereby authorize the indicated payee(s) below to charge my account the insurance premiums and fees due monthly.

(I have also included the first month's premium and fees payable to said payee(s).)

- GEM ADMINISTRATORS (VALUE HEALTH PLAN)
 UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA (UNL)
 (VALUE MED PLAN in AR, ID, IL, MO, ND, NE, NV, NM, OK, SD, TX, UT & WV)
 GUARANTEE TRUST LIFE INSURANCE COMPANY (GTL)
 (VALUE MED PLAN in approved states not listed above)

I understand my account will be charged once each month for the total amount shown as due for my monthly premium and fees for the term of the policy of insurance issued to me. I understand that if a charge to my account is not honored, my insurance coverage could lapse. I further agree that you will not be under any liability for any dishonored electronic withdraws from my account, for any reason, even though the dishonor results in the forfeiture of benefits or membership. If any ACH item is dishonored, I authorize any additional returned check fees resulting from said dishonored check, to be charged to my bank account. I understand that if I wish to cancel my coverage, I must inform the named insurance company above or GEM Administrators of such cancellation within 30 days of the withdrawal date. Please charge my monthly premium and fees against the following account.

Name of Depositor, as it appears on the Bank Institutions Records

Account Number Routing / Transit Number

Name of Banking Institution Branch

Address City Sate Zip

Please attach a voided check from the account you wish billed for your coverage.

X _____ Date Signed: _____

Coverage will not be issued without payment of the first month premium and fees.
MAKE THE CHECK (S) PAYABLE TO THE AUTHORIZED PAYEE INDICATED ABOVE.

Please Mail the completed forms and your check(s) to:

**VALUE BENEFITS OF AMERICA
15575 N. 79TH PLACE, SUITE 100
SCOTTSDALE, AZ 85260**

VBA Terms and Conditions:

- Member understands that VBA is not an insurance company or program. Accident Benefit Payments are made by the administrator for the insurance company issuing the blanket coverage to Members.
 - VBA provides savings to its members on services through a number of sources. The current list of benefits may be modified through additions or deletions. A quarterly newsletter, posted on our website or sent via e-mail, will keep Members up to date on benefits and other pertinent information.
 - Payments for the VBA Program are due in advance. Payments will be drafted on or about 15 days before the due date. If you choose to cancel your program, it is your responsibility to make sure that your membership card and a written request for cancellation are sent to VBA at least 15 days prior to the anniversary of your effective date in order for your account not to be charged for additional fees.
 - Member hereby appoints, Value Benefits of America Association (VBA) President, or failing this person, a VBA Director, as proxy holder for and on behalf of the member with the power of substitution to attend, act and vote for and on behalf of the member in respect of all matters that may properly come before the meeting of the members of VBA and at every adjournment thereof, to the same extent and with the same powers as if the undersigned member were present at the said meeting, or any adjournment thereof. Annual meetings are to be held in Arizona the second Tuesday of August.
 - VBA reserves the right to terminate any enrollment or deny eligibility in the program for lack of payment to VBA. Returned checks, insufficient notices on bank drafts or denial by the member's credit card company for payment of the membership fee is deemed to be evidence of non-payment by a member. There will be a \$10.00 charge to be reinstated in the program after such denial. If reinstatement for non-payment happens more than once, a \$20.00 reinstatement will apply.
 - In the event of any dispute, member agrees to resolve said dispute solely by binding arbitration that shall be governed by the laws of the state of Arizona and enforceable at Scottsdale, Maricopa County.
 - Membership cancelled within the first 30 days of the enrollment date may be eligible for refund if the membership card and written cancellation request are sent to VBA. The administrative fee is not refundable. Approved refunds will be processed approximately 30 days after cancellation.
 - Membership is effective on the 1st of the month following enrollment acceptance by VBA.
- Member Agreement:** By signing the enrollment form, Member expresses desire to become a member of Value Benefits of America. Member acknowledges that the discount plans ARE NOT INSURANCE, but membership may include certain limited supplemental insured coverage's. Membership benefits are not a replacement for health insurance coverage nor are they intended as a substitute for health insurance coverage. Membership fees may be changed for all members, but not individually, with notification.

MONTHLY PAYMENT CALCULATION FOR MEMBERS

PLEASE INDICATE PAYMENT METHOD:	<input type="checkbox"/> Monthly Bank Draft <input type="checkbox"/> Monthly List Bill *	
ENTER AMOUNT DUE:	Value Health Plan	Value Med Plan
1. VBA Classic Monthly Membership Level: ** <small>(Required if not a current VBA member)</small>	\$5.00	\$5.00 <small>(Only due if you are not also applying for the Value Health Plan)</small>
2. Value Health Plan:	\$	NA
3. Value Med Plan:	NA	\$
4. Monthly Administration Fee: <small>(Value Health Plan)</small>	\$15.00	NA
5. Total Monthly Due: ***	\$	\$
6. Note Payment instructions:	Make check payable to GEM Administrators.	Make check payable to GTL or UNL.

* Minimum for Monthly List Bill is 2 on Value Health and 5 on Value Med.
 ** If you have purchased another level of VBA Membership, the \$5.00 monthly dues are waived. I have purchased another level of VBA Membership. Yes No
 *** For Semi Annual or Annual payment modes, see below:

VALUE HEALTH PLAN:
 Semi-Annual:
 Add lines 2 + 4 and Multiply total by 6. Add \$30 for VBA dues if not already a member.
 Annual:
 Add lines 2 + 4 and Multiply total by 12. Add \$60 for VBA dues if not already a member.
VALUE MED PLAN
 Semi-Annual: See brochure for rates. Add \$30 for VBA dues if not already a member.
 Annual: See brochure for rates. Add \$60 for VBA dues if not already a member.

Marketed By: Bill Howell GAC # 76954

HIPAA AUTHORIZATION

This Authorization was prepared by for purposes of obtaining information necessary to underwrite my (our) application(s) for insurance.

**The United States Life Insurance Company in the City of New York
A member company of American International Group, Inc.
830 Third Avenue, New York, NY 10022**

I hereby authorize any licensed physician, medical practitioner, pharmacy benefit manager and other sources, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health, to give to United States Life or its reinsurers any such information. Such information will pertain to my employment, or other insurance carrier or medical care, advice, treatment or supplies for any physical or mental condition. This includes that information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by United States Life to collect and transmit such information.

I understand that this information will be used by United States Life solely to determine eligibility for insurance. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action, which United States Life has taken in reliance upon this authorization. I understand this authorization will not be valid after 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete.

I understand that my application for group insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (a) during the lifetime of all proposed insureds; and (b) while there is no change in the insurability or health of such person from that stated in the application.

(Print Please) Name of Applicant

Signature of Applicant and Date

ALL VALUE HEALTH PLATINUM LEVEL VBA MEMBERS RECEIVE

GALAXY PPO VALUECARE NETWORK:

The VBA Platinum program provides access to High Quality Healthcare for VBA Members through participating GALAXY Providers and Facilities. Previously negotiated fees* that can result in **ZERO balance billings from these Selected Facilities** and significant reductions in charges from other Providers combined with the Platinum Value Health Plan generous Hospital and Surgical benefits have bought this unique opportunity to the marketplace.

The VBA Platinum program is currently available in many communities across the nation. Contact your General Agent or check out <http://www.protectorbenefits.com/valuecare/> to learn if your community is among those already developed. We are working to develop this ValueCare Network Nationwide.

We are proud and excited to be pioneering this concept through Value Benefits of America". P.J. Shane., President, Galaxy Health Network *Negotiated PPO fees are based upon payment of charges within 30 days of receipt of service.

GALAXY PPO PHYSICIAN NETWORK:

The GALAXY Standard PPO Network is available Nationwide. "GALAXY Health Network has always been committed to providing access to the highest quality Providers at the lowest negotiated rates possible. Galaxy currently provides service access to over 3 and 1/2 million individuals nationwide.

With over 310,000 doctors in the United States participating in this Referral program, you can save on your doctor's bills. At a minimum, you will receive a **20% savings** on your actual bill from the **doctor's office**. Additionally, our Patient Advocacy Program will help you select a participating provider. To look up doctors or facilities go to <http://www.galaxyhealth.net/>

THE GALAXY MEDICAL SAVINGS CARD PROGRAM:

Valid at all participating "MSC Network" providers and facilities. This includes a network of Over 370,000 Healthcare Professionals and over 35,000 Hospitals and Ancillary Facilities. To look up doctors or facilities go to <http://www.galaxyhealth.net/>

The services offered include, but are not limited to:

- Primary Care Physicians ▪ Hospitals ▪ OB/GYN ▪ Pediatrics Chiropractic ▪ Home Health
- Alternative Care ▪ Specialists ▪ Labs / Clinics ▪ X-Ray ▪ Imaging ▪ Cosmetic ▪ Psychiatric
- Counseling ▪ Tertiary Care ▪ Acupuncture ▪ Vision ▪ and much more

MEDICAL SAVINGS 20% TO 30% OR MORE ON MEDICAL SERVICES: **

How it works – Member/Patient DOES NOT DIRECTLY CONTACT THE FACILITY, unless instructed to do so by a Galaxy Health Network Patient Advocacy Representative (PA). Scheduled Services include elective surgeries and other Hospital/ Facility based non-emergency treatment and services and must be arranged in advance through a PA. To be eligible for a discount, all Scheduled Services must be "paid-in-full" at the time they are rendered. Prior to admission, the PA will contact the Hospital/Facility to obtain a "good-faith" estimate of Discounted charges that may be incurred and confirm that the Member/Patient has secured adequate funds to make payment-in-full. When confirmation is made, a Referral Form including a Referral Number and "estimated charges" will be provided to the Member/Patient in writing by the PA.

**Newly negotiated discounted fees at SPECIFIC participating hospitals and facilities can be as high as 65%. ALL "MSC" Negotiated discounts are based upon payment of charges at or before performance of services. VBA has no liability for providing or guaranteeing service or for the quality of service rendered.

DISCOUNT BENEFITS ARE NOT INSURANCE