

HEALTH PLAN COMPANION BENEFITS

PROVIDED BY US HEALTHCARE ASSOCIATION

Dental:¹

Members have access to the largest dental networks in the country. Our networks have over 50,000 dental providers. There are no waiting periods and pre-existing conditions are accepted. When seeing a participating dentist you will save on average up to 60%. An average family savings of \$1200 is possible. Orthodontics and dentures included.

Vision:¹

Members can enjoy discounts up to 60% on eye glasses, contact lenses, non-prescription sunglasses, and other eyewear through a national network of over 10,000 eye care retail locations. Up to 30% savings on eye exams and surgical procedures including LASIK, RK, PRK and ALK.

Hearing:¹

As a member you will receive a 30% discount for all hearing exams and services, and up to a 58% discount on hearing aids at any network provider location. Over 200 models of hearing aids are available to you and include all styles. The plan offers all technology levels including the newest programmable and digital technology.

24-Hour Nurse Hotline:

Members have access to a toll-free healthcare hotline. Members can speak with registered nurses 24-hour a day, seven days a week for reassurance and professional recommendations for personal healthcare.

Medical Air Service:

Members have access to free emergency air ambulance services when miles away from a medical facility.

Gateway MediCard:

Members receive a free ID card where your medical profile is photographed on microfilm and laminated. Emergency Medical Technicians are able to read the card and treat you appropriately.

Accident Insurance²

Accident Insurance provides benefits for accidental bodily injuries. The program covers the services listed: hospital, out-patient surgery, ambulatory surgical center, or clinic charges; physician charges; licensed nurse charges; ground ambulance charges; charges for x-ray, laboratory tests, oxygen, casts, splints, crutches, braces, blood, blood plasma, drugs, medicines and treatment of natural teeth; charges for rental of durable medical equipment. We will pay for all injuries from any one accident, less the deductible of \$100, Excess Plan, and not to exceed the overall maximum benefit of \$2,000.00 per accident per insured. Accidental Death & Dismemberment Coverage of \$10,000.00 included.

Critical Illness Insurance²

This coverage pays a lump sum payment to offset the costs associated with critical illnesses including heart attack, coronary artery bypass, stroke, life threatening cancer, paralysis, kidney failure, coma, loss of sight, speech or hearing and severe burn. Critical Illness Insurance provides insureds with valuable protection and the freedom to choose the lifestyles and treatments they prefer. \$2500.00 benefit available for primary member and spouse only.

Tiered Prescription Drug Plan¹

PAY A MAXIMUM \$10.00 OR \$20.00 FOR SELECT GENERIC AND BRAND NAME DRUGS!

No Deductible; No Member Claim Forms; No Waiting Periods; Assistance to see if you qualify for Free Medicine (available to low income members); All Pre-existing Conditions Accepted; Over 50,000 Participating Pharmacies.

This plan provides you the opportunity to pay a maximum fixed cost of \$10 or \$20 for select Generic and Brand name drugs. There are over 2000+ Generic and Brand Name Drugs currently available in Tier One and Tier Two. Tier Three includes virtually all other drugs. These prescription drugs can be purchased, at the pharmacy, for the PBM-negotiated rate. This rate represents a reduction from the Average Wholesale Price, not the Average Retail Rate. Members also have access to a mail order pharmacy program that can save you 50% and more on mail order prescriptions.

¹ Neither the network savings benefits, nor the tiered prescription drug benefits are insurance. Pharmacy and Provider participation subject to change without notice. Drugs are subject to change without notice.

² Accident and Critical Illness Insurance underwritten by Insurers rated A-Excellent or better by A.M. Best, The Insurance Information Source. Coverage begins 30 days following your effective date with US HealthCare Association. For a complete listing of benefits, exclusions and limitations please refer to the certificates of coverage and your Member's Guide to Benefits and Services.

US HealthCare

A S S O C I A T I O N

1 FAMILY MEMBERS

FIRST NAME LAST NAME DATE OF BIRTH

Primary: _____

Spouse: _____

*Child: _____
*Dependent children under the age of 19 or under 23 if full-time student.

*Child: _____

*Child: _____

*Child: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ BUSINESS PHONE: _____

E-MAIL: _____

2 DUES INFO

INITIATION FEE (non-refundable): \$ 25.00

HEALTH PLAN COMPANION WITH ACCIDENT INSURANCE:

Individual: \$23.95 monthly Family: \$32.95 monthly DUES: \$ _____

CRITICAL ILLNESS PLAN:

\$15 member \$20 member & spouse DUES: \$ _____

Rx PLAN:

\$22.95 member \$29.95 member & spouse or single parent with child(ren) \$36.95 family DUES: \$ _____

TOTAL DUES: \$ _____

3 AGREEMENT

I understand that except for the Accident and Critical Illness Plans, the US HealthCare Association (USHA) benefit package is not an insurance plan. I am solely responsible for the contracted rate for the services rendered by providers.

I am enrolling to become a member of the USHA.

Signature of the Applicant: _____ DATE _____

X _____

Representative Name: _____

Representative #: _____

4 PAYMENT METHOD

Checking Account Deduction

Name of Bank or Financial Institution: _____

Account #: _____

Bank Routing No.: _____

SUBMIT THE TOTAL DUE AND A BLANK CHECK MARKED "VOID" (DEPOSIT SLIPS NOT ACCEPTABLE). The monthly recurring dues will be deducted from your checking account. If the account listed below is a joint account, both account holders' signatures are required. Monthly Checking Account Deduction Authorization - As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of US HealthCare Association (USHA) provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check drawn on you and signed personally by me. I authorize USHA to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my USHA dues. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit is dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of benefits.

Authorized Signature (as it appears in the financial institution's records) DATE

X _____

Authorized Signature (as it appears in the financial institution's records) DATE

X _____

Credit Card

Monthly Credit Card Authorization - As a convenience to me, I request and authorize you to charge my card for the initial amount due and for the recurring monthly dues. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of benefits.

VISA MasterCard Discover American Express

Card # _____ Exp Date: _____

Billing Address: _____

City: _____ State _____ Zip Code: _____

Cardholder Name (as it appears on the credit card) DATE

PLEASE PRINT

Authorized Signature (as it appears on the credit card) DATE

X _____

Monthly List Bill

(Organization enrollment with a minimum of ten members)

5 MAIL OR FAX WITH PAYMENT TO:

USHA P.O. Box 60298 • San Diego, CA 92166 Fax: 800-815-6201