

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 per day.....	\$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, uncontrolled high blood pressure, albumin or sugar in the urine, uncontrolled diabetes, cancer, tumors or ulcers? Yes No
- For conditions not listed in #1, have you or your dependents, if applying for insurance, during the past 12 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 _____ Agent's Number(s) _____

Payment Calculations For Members

Monthly VBA Classic Membership Level	\$ 5.00	
Monthly Insurance Coverage (<i>Includes \$15.00 Nonrefundable Admin Fee</i>)	\$ _____	MODE OF PAYMENT
Total Monthly Payment Due	\$ _____ **	<input type="checkbox"/> Monthly Bank Draft
<i>** (Semi-Annual X 6, Annual X 12, List Bill Groups - Minimum of 2)</i>		<input type="checkbox"/> List Bill
		<input type="checkbox"/> Semi-Annual
		<input type="checkbox"/> Annual
Please make check/money order payable to: GEM Administrators		
Send all forms and checks to: Value Benefits of America		
15575 N 79th PI - #100		
Scottsdale, AZ 85260		
 If you have purchased another level of VBA Membership, the \$5.00 dues are waived.		
I have purchased another level of VBA Membership <input type="checkbox"/> Yes <input type="checkbox"/> No		

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 the reverse side of this form.

Signature of Primary Member: **X** _____ Date Signed: _____

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

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.

Bank Draft Authorization Form

GEM ADMINISTRATORS AUTHORIZATION TO HONOR CHECKS, SHARE DRAFTS, OR ACCOUNT DEBITS

Name of Depositor as it appears on Banking Institution Records

Account Number	Routing/Transit Number	Name of Banking Institution	Branch
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Address	City	State	Zip
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As a convenience to me, I authorize you to pay and charge to my account checks, share drafts, electronic fund transfer debits or other account debits made upon my account by and payable to the order of the entity designated above or its legal representatives for membership, benefits and/or premiums. I agree that your treatment of each check, share draft or debit, and your rights with respect to it, will be the same as if it were signed or initiated personally by me. I further agree that if any check, share draft or debit is dishonored for any reason you will not be under any liability even though dishonor results in the forfeiture of benefits or membership. If any ACH item is dishonored, I authorize an additional returned check fee of the state allowable amount to be charged to my bank account. I further agree that this authorization is to remain in effect until you receive written notice from me of its revocation unless you end it earlier.

X _____ Date Signed: _____

VBA Terms and Conditions

1. 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.
2. 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.
3. 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.
4. 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.
5. 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.
6. 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.
7. 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.
8. Membership is effective on the 1st of the month following enrollment acceptance by VBA.

Member Agreement:

By signing the enrollment form on the reverse side, 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 coverages. 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.

Value Health Plan

Sales Representative Guidelines

Issue Date - All business must be received by the 20th for an issue date of the 1st of the following month.

Monies Collected - Make checks payable to: **GEM Administrators**.

Applicants can pay by Monthly Bank Draft, Semi-Annual, Annual or Monthly List Bill. All new business submitted must include the original application(s) and membership(s) with the first full payment. Make sure all your clients know; Billing will occur approximately 15 days before the due date. Bank Drafts will be drafted on or about the 25th of each month before the due date.

Faxed Apps

Faxed Bank Draft Apps need to be received with a voided check and a signed Bank Draft Authorization. If faxed, do not mail original app and/or money.

Email Address: Most correspondence is sent via email, so always include email address, if available. We will call the applicant if no email address is listed.

List Bill - No Participation Requirements on Groups

We will List Bill with 2 or more applications. You must submit first month's monies with all list bill cases. Please use the List Bill Form with all list bills.

Commission Payment

New business will be paid weekly upon issue and renewals on or about the 20th of each month.

Supplies - All supplies must be obtained through your marketing director. If you do not have a marketing director, you may phone in, fax or email your supply order. All supply orders will be shipped via US Mail or Ground.

Phone: (800) 366-2467

Fax: (480) 596-6518

Email: info@GeneralAgentCenter.com

Changes and Cancellations

Any changes, including cancellations, (administrative fees are non-refundable) must be in writing and sent to GEM Administrators • 919 N 1st St • Phoenix, AZ 85004 • Phone: (800) 756-4906

Fulfillment

All fulfillment information will be mailed directly to your client.

Child(ren) Only Coverage

When applying for child only coverage, you must charge the "19 year old adult rate" for the oldest child, then charge the child rate for younger children in the same family. If you are writing one child only, you must charge the "19 year old" adult rate.

Complete the Enrollment Form with the parent listed as the "Name of Member/Applicant". Write in after the parent's name, "Not To Be Covered". Complete all other sections of the Enrollment Form as normal.

Marketing (800) 366-2467

Administration (800) 756-4906

See Height & Weight Chart on reverse side

Common Medical Underwriting Conditions
NO RATE UPS OR ELIMINATIONS

Within **2 years**, the following are declines:

Kidney Dialysis, AIDS or HIV, Internal Cancer, Melanoma, Alzheimer's Disease, Lupus, Uncontrolled Diabetes, Uncontrolled High Blood Pressure, Heart Attack, Stroke, Emphysema , COPD, Leukemia, Parkinson's Disease, Drug or Alcohol Abuse, Multiple Sclerosis, Muscular Dystrophy, Anyone who has received Home Health Care or been confined in a Nursing Home or similar institution or been hospitalized for a major cause.

These are general rules. Other conditions may cause declines.

On groups over 25, please call if special underwriting consideration is needed.

HEIGHT & WEIGHT CHART

FEMALE			MALE		
Height	Min Weight	Max Weight	Height	Min Weight	Max Weight
4'8"	77	212	5'0"	91	234
4'9"	78	216	5'1"	93	237
4'10"	79	220	5'2"	95	243
4'11"	81	224	5'3"	98	247
5'0"	83	229	5'4"	101	256
5'1"	85	238	5'5"	103	262
5'2"	87	243	5'6"	106	270
5'3"	89	244	5'7"	109	276
5'4"	91	250	5'8"	112	286
5'5"	93	256	5'9"	115	296
5'6"	96	262	5'10"	118	299
5'7"	98	268	5'11"	121	308
5'8"	101	274	6'0"	124	312
5'9"	104	287	6'1"	127	323
5'10"	107	288	6'2"	131	328
5'11"	110	296	6'3"	134	339
6'0"	114	305	6'4"	138	360
6'1"	117	314	6'5"	142	385
6'2"	120	323	6'6"	146	409
			6'7"	150	418
			6'8"	154	427

SURGICAL BENEFIT

If, as a result of Sickness or Injury, an insured person requires surgery performed by a legally qualified Physician or surgeon, United States Life will pay a benefit. The benefit payable is equal to the Point Value for such procedure shown in the following Schedule of Operations multiplied by the Unit Value shown in the Schedule of Benefits.

In order for this benefit to be paid, the surgery must be performed in a Hospital or ambulatory (outpatient) surgical center. A benefit will not be paid for surgery: (1) performed in a Physician's office; or (2) to the extent a benefit is payable under the Emergency Accident Treatment Benefit.

The benefit for any surgical procedure not specified in the Schedule of Operations, will be the benefit for a similar procedure taking into account the nature and complexity of the procedure and any applicable exclusions and limitation of the coverage.

If two or more surgical procedures are performed through the same incision at the same time, the benefit payable will be for only one procedure. That procedure will be the principal procedure - the procedure providing the largest Point Value in the Schedule of Operations. If more than one procedure is performed at the same time but through separate incisions, the aggregate benefit payable will be equal to the amount payable for the principal procedure plus 50% of the amount payable for all other procedures performed at the same time.

For the administration of anesthesia during a covered surgery, United States Life will also pay a benefit equal to 20% of the Surgical Benefit.

UNIT VALUE

Classic = \$25.00
Silver = \$50.00
Gold = \$75.00
Platinum = \$100.00

Schedule of Operations

The Maximum Payment for each operation may be determined by multiplying the Point Value shown below by the Unit Value shown in the Schedule of Benefits.

BRAIN & NERVE

Craniotomy for drainage of brain abscess	75.0
Excision of brain tumor, sub-occipital	150.0
Laminectomy, for lesion of spinal cord	100.0
Laminectomy, for removal of intervertebral discs	90.0
Plastic operation on skull with bone graft or metal or plastic plate	100.0
Spinal puncture, lumbar (independent procedure)	2.0
Sympathectomy, lumbar, unilateral	55.0
Sympathectomy, lumbar, bilateral	75.0

BREAST

Excision biopsy of breast	15.0
Excision of cyst, tumor or part of breast	15.0
Simple removal of breast	30.0
Radical removal of breast	70.0

BONES & JOINTS

Dislocation of hip, simple, closed reduction	20.0
Dislocation of hip, simple, open reduction	60.0
Dislocation of knee, simple, closed reduction	20.0
Dislocation of knee, simple, open Reduction	60.0
Dislocation of shoulder, simple closed reduction with anesthesia	5.0
Excision of cyst, tumor or growth, large bones	40.0
Excision of cyst, tumor or growth, small bones	25.0

Excision of intervertebral disc	90.0
Excision of intervertebral disc with spinal fusion, posterior technique.....	120.0
Excision of semilunar cartilage of knee joint	50.0
Excision of hip joint	100.0
Fracture of collarbone, simple, closed reduction.....	15.0
Fracture of collarbone, simple, open reduction	40.0
Fracture of forearm, one bone, simple, closed reduction.....	20.0
Fracture of forearm, one bone, simple, open reduction	40.0
Fracture of forearm, both bones, simple, closed reduction	25.0
Fracture of forearm, both bones, simple, open reduction	50.0
Fracture of wrist (Colles), simple, closed reduction.....	15.0
Fracture of wrist (Colles), simple, open reduction	40.0
Fracture of finger or thumb, simple, closed reduction.....	7.5
Fracture of finger or thumb, simple, open reduction.....	20.0
Fracture of ankle (Potts) simple closed reduction.....	25.0
Fracture of ankle (Potts) simple open reduction.....	50.0
Fracture of toe, simple, closed reduction	5.0
Fracture of great toe, open reduction	15.0
Fracture of other toes, open reduction	12.0
Puncture of joint for aspiration	2.0
Spinal fusion cervical region, posterior technique.....	90.0
CARDIOVASCULAR SYSTEM	
Aortic or mitral, valvuloplasty for stenosis or insufficiency (open).....	200.0
Aortic or mitral, replacement (open)	200.0
Ligation of femoral vein	25.0
Ligation and division of common iliac vein	50.0
Repair of heart valve, aortic valvotomy (commissurotomy)(closed).....	150.0
Repair of heart valve, mitral valvotomy (commissurotomy)(closed).....	140.0
Varicose veins - Ligation and division of long saphenous vein at saphenofemoral junction.....	20.0
Varicose veins - Ligation and division and complete tripping of long or short saphenous veins, unilateral	30.0
Varicose veins - Ligation and division and complete tripping of long and short saphenous veins, unilateral.....	40.0
DIGESTIVE SYSTEM	
Excision of hemorrhoids, external, complete.....	20.0
Excision of hemorrhoids, Internal and external	30.0
Excision of hemorrhoids, with excision of fistula	40.0
Excision of hemorrhoids, with excision of fissure.....	30.0
Excision of rectal fissure, with or without sphincterotomy	20.0
Excision of rectum, complete, combined abdominoperineal, one or two stages	100.0
Excision of stomach ulcer or benign tumor.....	60.0
Incision of rectal fistula, superficial	10.0
Removal of appendix	40.0
Removal of stomach, subtotal, with vagotomy.....	80.0
Removal of stomach, subtotal, without vagotomy	90.0
Resection of small intestine, with anastomosis.....	70.0
Resection of large intestine, in two stages, including first state colostomy.....	100.0
Removal of gall bladder.....	50.0
Removal of gall bladder with open exploration of common duct	70.0
Repair of inguinal hernia, unilateral	35.0
Repair of inguinal hernia, unilateral, with orchiectomy	40.0
Repair of inguinal hernia, unilateral, with excision of hydrocele	40.0
Repair of femoral hernia, unilateral	35.0
EAR	
Fenestration of semicircular canals	100.0
Revision of fenestration operation	60.0
Incision of ear drum	3.0
Stapes Mobilization.....	70.0

EYE

Excision of pterygium	25.0
Extraction of lens for cataracts, unilateral	80.0
Eye muscle operation, one or more muscles, one or both eyes, single stage	60.0
Eye muscle transplant	70.0
Needling of lens for cataracts, initial	20.0
Needling of lens for cataracts, subsequent	10.0
Reattachment of retina, electrocoagulation, initial	100.0
Removal of foreign body from surface of cornea	2.0

FEMALE GENITAL SYSTEM

Biopsy of cervix or endometrium (independent procedure)	3.0
Biopsy of ovary, unilateral or bilateral (independent procedure)	45.0
Excision of lesion of cervix	3.0
Repair of cystocele and rectocele	50.0
Repair of cystocele (independent procedure)	35.0
Repair of rectocele (independent procedure)	30.0
Removal of ovary, unilateral or bilateral (independent procedure)	45.0
Total hysterectomy (corpus and cervix)	60.0
Vaginal hysterectomy, with or without pelvic floor repair	70.0
Dilation and curettage or uterus (independent procedure)	15.0

MALE GENITAL SYSTEM

Circumcision, newborn	3.0
Excision of varicocele (independent procedure), unilateral	30.0
Excision of varicocele, unilateral, with hernia repair	40.0
Repair of hydrocele, unilateral	20.0
Resection of prostate, perineal, subtotal	80.0
Resection of prostate, perineal, radical	100.0
Resection of prostate, transurethral, including control at post-operative bleeding, complete	80.0

MUSCLES AND TENDONS

Excision of Baker's cyst (synovial cyst of popliteal space)	30.0
Excision of ganglion, wrist	15.0
Lengthening or shortening tendon	30.0

RESPIRATORY SYSTEM

Antrotomy, intranasal, unilateral	15.0
Antrotomy, intranasal, bilateral	25.0
Antrotomy, radical (Caldwell-Luc), unilateral	50.0
Antrum puncture, maxillary sinus, unilateral	2.0
Bronchoscopy diagnostic	15.0
Bronchoscopy diagnostic, with removal of foreign body	25.0
Excision of nasal polyp, single or multiple, unilateral or bilateral	20.0
Removal of lung	100.0
Submucous resection, classic, Nasal Septum	30.0
Thoracotomy, exploratory, including control of hemorrhage and/or repair of lung fistula	75.0

SKIN & SUBCUTANEOUS TISSUE

Drainage of boil, carbuncle, or subcutaneous abscess	2.0
Excision of pilonidal cyst or sinus	30.0
Suture of small wound (up to 2 ½ inches)	2.0

THYROID

Excision of small cyst or tumor of thyroid	40.0
Resection of thyroid, total or complete	70.0
Resection of thyroid, subtotal or partial	60.0
Thyroidectomy, total or subtotal, for malignancy with radical neck dissection	100.0

TONSILS AND ADENOIDS

Removal of tonsils, with or without adenoids, under age 18	15.0
Removal of tonsils, with or without adenoids, age 18 years or over	20.0
Removal of adenoids (independent procedure).....	10.0

URINARY SYSTEM

Cystoscopy, diagnostic.....	8.0
Cystoscopy, diagnostic, with ureteral catheterization	15.0
Cystoscopy, diagnostic, with biopsy	10.0
Cystoscopy, diagnostic, with biopsy and fulguration of small bladder tumor	25.0
Cystoscopy, diagnostic, with removal of stone from ureter.....	30.0
Removal of kidney	80.0
Resection of bladder neck, transurethral, female.....	50.0
Resection of bladder tumor, transurethral, large.....	80.0

SAMPLE