IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

NOELLE LeCANN, KRISTIN SELIMO, and TANIA FUNDUK, on behalf of themselves and others similarly situated,	)	
Plaintiffs,	)	**CIVIL ACTION NO. 1:20-CV-02429-AT**
vs.	)	
THE ALIERA COMPANIES, INC., formerly known as ALIERA HEALTHCARE, INC.,	)	
Defendant.	)	

DEFENDANT THE ALIERA COMPANIES INC.'S MOTION TO DISMISS, OR ALTERNATIVELY, TO COMPEL ARBITRATION AND TO STAY PROCEEDINGS

Defendant The Aliera Companies Inc. ("Aliera") moves this Court to dismiss Plaintiffs' Complaint without prejudice, or alternatively, Aliera moves under 9 U.S.C. §§ 3-4 for the Court (i) to compel Plaintiffs to submit their claims to arbitration, and (ii) to stay all proceedings in this case during the pendency of the arbitration proceedings.

1. Plaintiffs' complaint should be dismissed without prejudice because Plaintiffs failed to mediate their disputes. Failure to mediate a dispute pursuant to

an agreement to mediate warrants dismissal of litigation. *World of Beer Franchising, Inc. v. MWB Dev. I, LLC*, 711 F. App'x 561, 566-68 (11th Cir. 2017).

2. Alternatively, the Court should send the matter to arbitration. Not only are all of Plaintiffs' substantive claims against Aliera subject to arbitration, but all defenses to arbitration Plaintiffs could possibly mount should also be resolved by the arbitrator. The arbitrator, moreover, can decide whether the Plaintiffs' claims can proceed in arbitration until after a mediation occurs. *See BG Grp., PLC v. Republic of Argentina*, 572 U.S. 25, 35 (2014) (arbitrators usually decide whether pre-arbitration procedural requirements have been followed).

3. Finally, under 9 U.S.C. § 3, a court, "upon being satisfied that the issue involved in such suit or proceeding is referable to arbitration under such an agreement, *shall* on application of one of the parties stay the trial of the action until such arbitration has been had in accordance with the terms of the agreement." (emphasis added). If this Court does not dismiss this matter entirely for failure to comply with conditions precedent to suit, Aliera requests that this Court follow the mandate of Section 3 and stay the proceedings until arbitration is completed. *See Schklar v. Evans*, No. 1:15-cv-2265-AT, 2015 WL 9913859, at * 4 (N.D. Ga. Dec. 29, 2015).

4. As grounds for this Motion, Aliera relies upon the Complaint, the Declaration of Kathleen Kromodimedjo attached hereto as Exhibit "A," and the accompanying Memorandum of Law.

Respectfully submitted on July 16, 2020.

/s/ Sarah R. Craig
Sarah R. Craig
Georgia Bar No. 463578
Primary Email: scraig@burr.com
BURR & FORMAN, LLP
One Tampa City Center
201 North Franklin Street, Ste. 3200
Tampa, Florida 33602
Telephone: (813) 367-5766
Facsimile: (813) 221-7335

Counsel for Defendant,
The Aliera Companies Inc.

CERTIFICATE OF SERVICE

A copy of the foregoing **DEFENDANT ALIERA'S MOTION TO DISMISS, OR ALTERNATIVELY, TO COMPEL ARBITRATION AND TO STAY PROCEEDINGS** has been filed this 16th day of July, 2020 via the Court's CM/ECF system, which will send notification of such filing to all parties of record as noted below.

David F. Walbert
Jennifer Kathleen Coalson
Parks Chesin & Walbert, P.C. – Atlanta
Suite 2600
75 Fourteenth Street, N.E.
Atlanta, GA 30309
dwalbert@pcwlawfirm.com
jcoalson@pcwlawfirm.com

Paul Sweeny
Stephen J. Fearon, Jr.
Squitieri & Fearson, LLP – New York
32 East 57th Street
New York, NY 10022
paul@sfclasslaw.com
stephen@sfclasslaw.com

/s/ Sarah R. Craig
OF COUNSEL

DEFENDANT THE ALIERA COMPANIES INC.'S MOTION TO DISMISS, OR ALTERNATIVELY, TO COMPEL ARBITRATION AND TO STAY PROCEEDINGS

EXHIBIT A

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

NOELLE LeCANN, KRISTIN SELIMO, and TANIA FUNDUK, on behalf of themselves and others similarly situated,	)	
Plaintiffs,	)	**CIVIL ACTION NO. 1:20-CV-02429-AT**
vs.	)	
THE ALIERA COMPANIES, INC., formerly known as ALIERA HEALTHCARE, INC.,	)	
Defendant.	)	

DECLARATION OF KATHLEEN KROMODIMEDJO

I, Kathleen Kromodimedjo, declare as follows:

1. I am over the age of twenty-one years, and I am competent to testify regarding the matters contained herein. I make this Declaration based on my personal knowledge and my review of relevant business records, true and correct copies of which are attached hereto.

2. I am the Director of Risk and Compliance for The Aliera Companies Inc. (formerly known as Aliera Healthcare, Inc.) (or "Aliera"). I am authorized by Aliera to execute documents on its behalf. I am familiar with the business and operations of Aliera.

3. Aliera is a corporation organized and existing under the laws of the State of Delaware, with its principal place of business in the State of Georgia.

4. Aliera's subsidiaries provide various services related to the operation and administration of Trinity Healthshare, Inc.'s ("Trinity") healthcare sharing ministry ("HCSM") – also known as an "ASO," or administrative services only administrator. Aliera and Trinity are different companies, with different management and operations. They have various business contracts between them, negotiated at arms-length. Aliera is an associate of Trinity. Aliera is not a HCSM.

5. Prior to Aliera's subsidiaries providing various administrative services to Trinity, Aliera provided various administrative services related to the operation and administration of Unity Healthshare, LLC's ("Unity") healthcare sharing ministry. Unity and Aliera are different companies, with different management and operations. Aliera was an associate of Unity.

Plaintiff Noelle LeCann

6. Plaintiff Noelle LeCann (or "LeCann") was a Unity member from August 1, 2018 to May 31, 2019. (*See* Exhibit 1, attached hereto.) Thereafter, LeCann became a Trinity member, effective June 1, 2019. (*See* Exhibit 2, attached hereto, which is an executed transition authorization from Unity's HCSM to Trinity's HCSM.) LeCann terminated her Trinity membership as of November 30, 2019. (Exhibit 3, attached hereto, which is LeCann's cancellation request with

regard to Trinity's HCSM.) LeCann has not had a business relationship with Unity and Aliera or with Trinity and Aliera since that time.

7. As part of her membership in Unity's HCSM, LeCann received a copy of and agreed to Unity's Member Guide, among other documents. (Exhibit 4, attached hereto, which is LeCann's Unity Member Guide.) In conjunction with becoming a Unity member and after receiving the Unity Member Guide, LeCann made voluntary member sharing contributions each month for the period of August 1, 2018 to May 31, 2019.

8. Among other provisions, the Unity Member Guide provides within the first few pages of the Guide a conspicuous disclaimer that membership in Unity is a faith-based, voluntary sharing membership, and it is not insurance:

Disclaimer

AlieraCare offering by Unity Healthshare, LLC, through Aliera Healthcare, Inc., is a faith-based medical needs sharing membership. Medical needs are only shared by the members according to the membership guidelines. Our members agree to the Statement of Beliefs and voluntarily submit monthly contributions into a cost sharing account with Unity Healthshare, LLC, acting as a neutral clearing house between members. Organizations like ours have been operating successfully for years. We are including the following caveat for all to consider:

> This publication or membership is not issued by an insurance company, nor is it offered through an insurance company. This publication or the membership does not guarantee or promise that your eligible medical needs will be shared by the membership. This publication or the membership should never be considered as a substitute for an insurance policy. If the publication or the membership is unable to share in all or part of your eligible medical needs, or whether or not this membership continues to operate, you will remain financially liable for any and all unpaid medical needs.

This is not a legally binding agreement to reimburse any member for medical needs a member may incur, but is instead, an opportunity for members to care for one another in a time of need, to present their medical needs to other members as outlined in the membership guidelines. The financial assistance members receive will come from other members' monthly contributions that are placed in a sharing account, not from Unity Healthshare, LLC.

(Ex. 4, at p. 5.)

9. The Unity Member Guide also contains a disclaimer that it is not insurance or offered through an insurance company and that whether medical bills may be paid is totally voluntary, pursuant to Georgia law:

Georgia Statute 33-1-20

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

(Ex. 4, at p. 43.)

10. Further, the Unity Member Guide provides for alternative dispute resolution, including appeals, mediation and arbitration:

DISPUTE RESOLUTION AND APPEAL

Unity Healthshare, LLC is a voluntary association of like-minded people who come together to assist each other by sharing medical expenses. Such a sharing and caring association does not lend itself well to the mentality of legally enforceable rights. However, it is recognized that differences of opinion will occur, and that a methodology for resolving disputes must be available. Therefore, by becoming a Sharing Member of Unity Healthshare, LLC, you agree that any dispute you have with or against Unity Healthshare, LLC, its associates, or employees will be settled using the following steps of action, and only as a course of last resort.

If a determination is made with which the sharing member disagrees and believes there is a logically defensible reason why the initial determination is wrong, then the sharing member may file an appeal.

A. 1st Level Appeal. Most differences of opinion can be resolved simply by calling Unity Healthshare, LLC who will try to resolve the matter telephonically within a reasonable amount of time.

B. 2nd Level Appeal. If the sharing member is unsatisfied with the determination of the member services representative, then the sharing member may request a review by the Internal Resolution Committee, made up of three Unity Healthshare, LLC officials. The appeal must be in writing, stating the elements of the dispute and the relevant facts. Importantly, the appeal should address all of the following:

1. What information does Unity Healthshare, LLC have that is either incomplete or incorrect?
2. How do you believe Unity Healthshare, LLC has misinterpreted the information already on hand?
3. Which provision in the Unity Healthshare, LLC Guidelines do you believe Unity Healthshare, LLC applied incorrectly?

Within thirty (30) days, the Internal Resolution Committee will render a written decision, unless additional medical documentation is required to make an accurate decision.

C. 3rd Level Appeal. Should the matter remain unresolved, then the aggrieved party may ask that the dispute be submitted to three sharing members in good standing and randomly chosen by Unity Healthshare, LLC, who shall agree to review the matter and shall constitute an External Resolution Committee. Within thirty (30) days the External Resolution Committee shall render their opinion in writing, unless additional medical documentation is required to make an accurate decision.

DISPUTE RESOLUTION AND APPEAL

D. **Final Appeal.** If the aggrieved sharing member disagrees with the conclusion of his/her fellow sharing members, then the aggrieved party may ask that the dispute be submitted to a medical expense auditor, who shall have the matter reviewed by a panel consisting of personnel who were not involved in the original determination and who shall render their opinion in writing within thirty (30) days, unless additional medical documentation is required to make an accurate decision.

E. **Mediation and Arbitration.** If the aggrieved sharing member disagrees with the conclusion of the Final Appeal Panel, then the matter shall be resolved by first submitting the disputed matter to mediation. If the dispute is not resolved the matter will be submitted to legally binding arbitration in accordance with the Rules and Procedure of the American Arbitration Association. Sharing members agree and understand that these methods shall be the sole remedy to resolve any controversy or claim arising out of the Sharing Guidelines, and expressly waive their right to file a lawsuit in any civil court against one another for such disputes; except to enforce an arbitration decision. Any arbitration shall be held in Atlanta, Georgia, and conducted in the English language subject to the laws of the State of Georgia. Unity Healthshare, LLC shall pay the filing fees for the arbitration and arbitrator in full at the time of filing. All other expenses of the arbitration shall be paid by each party including costs related to transportation, accommodations, experts, evidence gathering, and legal counsel. Further agreed that the aggrieved sharing member shall reimburse the full costs associated with the arbitration, should the arbitrator render a judgment in favor of Unity Healthshare, LLC and not the aggrieved sharing member.

> The aggrieved sharing member agrees to be legally bound by the arbitrator's final decision. The parties may alternatively elect to use other professional arbitration services available in the Atlanta metropolitan area, by mutual agreement.

(Ex. 4, at pp. 32-33.)

11. LeCann has not completed the dispute resolution process. More specifically, she has not exhausted the various levels of appeal. She has not submitted a request for or participated in mediation. She has not submitted a request for or participated in arbitration.

12. Likewise, as part of her membership in Trinity's HCSM, LeCann received a copy of and agreed to Trinity's Member Guide, among other documents. (*See* Exhibit 5, attached hereto, which is LeCann's Trinity Member Guide.) In conjunction with becoming a Trinity member and after receiving the Trinity Member Guide, LeCann made voluntary member sharing contributions each month for the period of June 1, 2019 to November 30, 2019.

13. Among other provisions, LeCann's Trinity Member Guide provides within the first few pages a conspicuous disclaimer that membership in Trinity is a faith-based, voluntary sharing membership, and it is not insurance:

DISCLAIMER

AlieraCare offering by Trinity HealthShare, through Aliera Healthcare, Inc., is a faith-based medical needs sharing membership. Medical needs are only shared by the members according to the membership guidelines. Our members agree to the Statement of Beliefs and voluntarily submit monthly contributions into a cost-sharing account with Trinity HealthShare, acting as a neutral clearing house between members. Organizations like ours have been operating successfully for years. We are including the following caveat for all to consider:

> This publication or membership is not issued by an insurance company, nor is it offered through an insurance company. This publication or the membership does not guarantee or promise that your eligible medical needs will be shared by the membership. This publication or the membership should never be considered as a substitute for an insurance policy. If the publication or the membership is unable to share in all or part of your eligible medical needs, or whether or not this membership continues to operate, you will remain financially liable for any and all unpaid medical needs.
>
> This is not a legally binding agreement to reimburse any member for medical needs a member may incur, but is instead, an opportunity for members to care for one another in a time of need, to present their medical needs to other members as outlined in the membership guidelines. The financial assistance members receive will come from other members' monthly contributions that are placed in a sharing account, not from Trinity HealthShare.

(Ex. 5, at p. 3.)

14. The Trinity Member Guide also contains a disclaimer that it is not insurance or offered through an insurance company and that whether medical bills may be paid is totally voluntary, pursuant to Georgia law:

Georgia Statute 33-1-20

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

(Ex. 5, at p. 46.)

15. Further, the Trinity Member Guide provides for alternative dispute resolution, including appeals, mediation and arbitration:

DISPUTE RESOLUTION AND APPEAL

Trinity HealthShare is a voluntary association of like-minded people who come together to assist each other by sharing medical expenses. Such a sharing and caring association does not lend itself well to the mentality of legally enforceable rights. However, it is recognized that differences of opinion will occur, and that a methodology for resolving disputes must be available. Therefore, by becoming a Sharing Member of Trinity HealthShare, you agree that any dispute you have with or against Trinity HealthShare, its associates, or employees will be settled using the following steps of action, and only as a course of last resort.

If a determination is made with which the sharing member disagrees and believes there is a logically defensible reason why the initial determination is wrong, then the sharing member may file an appeal.

A. 1st Level Appeal. Most differences of opinion can be resolved simply by calling Trinity HealthShare who will try to resolve the matter telephonically within a reasonable amount of time.

B. 2nd Level Appeal. If the sharing member is unsatisfied with the determination of the member services representative, then the sharing member may request a review by the Internal Resolution Committee, made up of three Trinity HealthShare officials. The appeal must be in writing, stating the elements of the dispute and the relevant facts. Importantly, the appeal should address all of the following:

1. What information does Trinity HealthShare have that is either incomplete or incorrect?

2. How do you believe Trinity HealthShare has misinterpreted the information already on hand?

3. Which provision in the Trinity HealthShare Guidelines do you believe Trinity HealthShare applied incorrectly?

Within thirty (30) days, the Internal Resolution Committee will render a written decision, unless additional medical documentation is required to make an accurate decision.

C. 3rd Level Appeal. Should the matter remain unresolved, then the aggrieved party may ask that the dispute be submitted to three sharing members in good standing and randomly chosen by Trinity HealthShare, who shall agree to review the matter and shall constitute an External Resolution Committee. Within thirty (30) days the External Resolution Committee shall render their opinion in writing, unless additional medical documentation is required to make an accurate decision.

D. Final Appeal. If the aggrieved sharing member disagrees with the conclusion of his/her fellow sharing members, then the aggrieved party may ask that the dispute be submitted to a medical expense auditor, who shall have the matter reviewed by a panel consisting of personnel who were not involved in the original determination and who shall render their opinion in writing within thirty (30) days, unless additional medical documentation is required to make an accurate decision.

> **E. Mediation and Arbitration.** If the aggrieved sharing member disagrees with the conclusion of the Final Appeal Panel, then the matter shall be resolved by first submitting the disputed matter to mediation. If the dispute is not resolved the matter will be submitted to legally binding arbitration in accordance with the Rules and Procedure of the American Arbitration Association. Sharing members agree and understand that these methods shall be the sole remedy to resolve any controversy or claim arising out of the Sharing Guidelines, and expressly waive their right to file a lawsuit in any civil court against one another for such disputes; except to enforce an arbitration decision. Any arbitration shall be held in Atlanta, Georgia, and conducted in the English language subject to the laws of the State of Georgia. Trinity HealthShare shall pay the filing fees for the arbitration and arbitrator in full at the time of filing. All other expenses of the arbitration shall be paid by each party including costs related to transportation, accommodations, experts, evidence gathering, and legal counsel. Further agreed that the aggrieved sharing member shall reimburse the full costs associated with the arbitration, should the arbitrator render a judgment in favor of Trinity HealthShare and not the aggrieved sharing member.
>
> The aggrieved sharing member agrees to be legally bound by the arbitrator's final decision. The parties may alternatively elect to use other professional arbitration services available in the Atlanta metropolitan area, by mutual agreement.

(Ex. 5, at pp. 34-35.)

16. LeCann has not completed the dispute resolution process. More specifically, she has not exhausted the various levels of appeal. She has not submitted a request for or participated in mediation. She has not submitted a request for or participated in arbitration.

Plaintiff Kristin Selimo

17. Plaintiff Kristin Selimo (or "Selimo") was a Unity member from February 15, 2018 to November 14, 2019. Effective November 15, 2019, Selimo became a member of Trinity's HCSM. (*See* Exhibit 6, attached hereto, which is a copy of an electronically signed email whereby Selimo agreed to become a Trinity member.) Selimo terminated the Trinity membership as of May 14, 2020. Selimo has not had a business relationship with Unity and Aliera or with Trinity and Aliera since that time.

18. As part of her membership in Unity's HCSM, Selimo received a copy of and agreed to Unity's Member Guide, among other documents. (Exhibit 7, attached hereto, which is Selimo's Unity Member Guide.) In conjunction with becoming a Unity member and after receiving the Unity Member Guide, Selimo made voluntary member sharing contributions each month for the period of February 15, 2018 to November 14, 2019.

19. Among other provisions, the Unity Member Guide provides within the first few pages of the Guide a conspicuous disclaimer that membership in Unity is a faith-based, voluntary sharing membership, and it is not insurance:

Disclaimer
Unity HealthShare[SM] is a faith-based medical need sharing membership. Medical needs are only shared by the members according to the membership guidelines. Our members agree to the Statement of Beliefs and voluntarily submit monthly contributions into a cost sharing account with Unity HealthShare, acting as a neutral clearing house between members. Organizations like ours have been operating successfully for years. We are including the following caveat for all to consider:

> *This publication or membership is not issued by an insurance company, nor is it offered through an insurance company. This publication or the membership does not guarantee or promise that your eligible medical needs will be shared by the membership. This publication or the membership should never be considered as a substitute for an insurance policy. If the publication or the membership is unable to share in all or part of your eligible medical needs, or whether or not this membership continues to operate, you will remain financially liable for any and all unpaid medical needs.*
>
> *This is not a legally binding agreement to reimburse any member for medical needs a member may incur, but is instead, an opportunity for members to care for one another in a time of need and to present their medical needs to other members as outlined in the membership guidelines. The financial assistance members receive will come from other members' monthly contributions that are placed in a sharing account, not from Unity HealthShare.*

(Ex. 7, at p. 3.)

20. The Unity Member Guide also contains a disclaimer that it is not insurance or offered through an insurance company and that whether medical bills may be paid is totally voluntary, pursuant to Georgia law:

Georgia Statute 33-1-20
Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

(Ex. 7, at p. 23.)

21. Further, the Unity Member Guide provides for alternative dispute resolution, including appeals, mediation and arbitration:

DISPUTE RESOLUTION AND APPEAL

Unity HealthShare[SM] is a voluntary association of like-minded people who come together to assist each other by sharing medical expenses. Such a sharing and caring association does not lend itself well to the mentality of legally enforceable rights. However, it is recognized that differences of opinion will occur, and that a methodology for resolving disputes must be available. Therefore, by becoming a Sharing Member of Unity HealthShare[SM], you agree that any dispute you have with or against Unity HealthShare[SM], its associates, or employees will be settled using the following steps of action, and only as a course of last resort.

If a determination is made with which the sharing member disagrees and believes there is a logically defensible reason why the initial determination is wrong, then the sharing member may file an appeal.

A. **1st Level Appeal**. Most differences of opinion can be resolved simply by calling Unity HealthShare[SM] who will try to resolve the matter within ten (10) working days in writing.

B. **2nd Level Appeal.** If the sharing member is unsatisfied with the determination of the member services representative, then the sharing member may request a review by the Internal Resolution Committee, made up of three Unity HealthShare[SM] officials: the needs processing manager, the assistant director, and the executive director. The appeal must be in writing, stating the elements of the dispute and the relevant facts. Importantly, the appeal should address all of the following:

1. What information does Unity HealthShare[SM] have that is either incomplete or incorrect?
2. How do you believe Unity HealthShare[SM] has misinterpreted the information already on hand?
3. Which provision in the Unity HealthShare[SM] Guidelines do you believe Unity HealthShare[SM] applied incorrectly?

Within thirty (30) days, the Internal Resolution Committee will render a written decision.

C. **3rd Level Appeal.** Should the matter remain unresolved, then the aggrieved party may ask that the dispute be submitted to three sharing members in good standing and randomly chosen by Unity HealthShare[SM], who shall agree to review the matter and shall constitute an External Resolution Committee. Within thirty (30) days the External Resolution Committee shall render their opinion in writing.

D. **Final Appeal.** If the aggrieved sharing member disagrees with the conclusion of his/her fellow sharing members, then the aggrieved party may ask that the dispute be submitted to a medical expense auditor, who shall have the matter reviewed by a panel consisting of personnel who were not involved in the original determination and who shall render their opinion in writing within thirty (30) days.

E. **Mediation and Arbitration.** If the aggrieved sharing member disagrees with the conclusion of the Final Appeal Panel, then the matter shall be settled by mediation and, if necessary, legally binding arbitration in accordance with the Rules of Procedure for Christian Conciliation of the Institute for Christian Conciliation, a division of Peacemaker Ministries. Judgment upon an arbitration decision may be entered in any court otherwise having jurisdiction. Sharing members agree and understand that these methods shall be the sole remedy for any controversy or claim arising out of the Sharing Guidelines and expressly waive their right to file a lawsuit in any civil court against one another for such disputes, except to enforce an arbitration decision. Any such arbitration shall be held in Fredericksburg, Virginia, subject to the laws of the Commonwealth of Virginia. Unity HealthShare[SM] shall pay the fees of the arbitrator in full and all other expenses of the arbitration; provided, however, that each party shall pay for and bear the cost of its own transportation, accommodations, experts, evidence, and legal counsel, and provided further that the aggrieved sharing member shall reimburse the full cost of arbitration should the arbitrator determine in favor of Unity HealthShare[SM] and not the aggrieved sharing member. The aggrieved sharing member agrees to be legally bound by the arbitrator's decision. The Rules of Procedure for Christian Conciliation of the Institute for Christian Conciliation, a division of Peacemaker Ministries, will be the sole and exclusive procedure for resolving any dispute between individual members and Unity HealthShare[SM] when disputes cannot be otherwise settled.

(Ex. 7, at p. 17.)

22. Selimo has not completed the dispute resolution process. More specifically, she has not exhausted the various levels of appeal. She has not submitted a request for or participated in mediation. She has not submitted a request for or participated in arbitration

23. Likewise, as part of her membership in Trinity's HCSM, Selimo received a copy of and agreed to Trinity's Member Guide, among other documents. In conjunction with becoming a Trinity member and after receiving the Trinity Member Guide, Selimo made voluntary member sharing contributions each month

for the period of November 15, 2019 to May 14, 2020, when she terminated her Trinity membership.

Plaintiff Tania Funduk

24. Plaintiff Tania Funduk (or "Funduk") was a Unity member from March 1, 2018 to June 30, 2018. (*See* Exhibits 8 and 9, attached hereto.) Effective November 1, 2018, Funduk became a member of Trinity's HCSM. (*See* Exhibit 10, attached hereto, which is a copy of an electronically signed email whereby Funduk agreed to become a Trinity member.) Funduk cancelled her Trinity membership effective June 30, 2019. Funduk has not had a business relationship with Unity and Aliera or with Trinity and Aliera since that time.

25. As part of her membership in Unity's HCSM, Funduk received a copy of and agreed to Unity's Member Guide, among other documents. (Exhibit 11, attached hereto, which is Funduk's Unity Member Guide.) In conjunction with becoming a Unity member and after receiving the Unity Member Guide, Funduk made voluntary member sharing contributions each month for the period of March 1, 2018 to June 30, 2018.

26. Among other provisions, the Unity Member Guide provides within the first few pages of the Guide a conspicuous disclaimer that membership in Unity is a faith-based, voluntary sharing membership, and it is not insurance:

Disclaimer
Unity HealthShare[SM] is a faith-based medical need sharing membership. Medical needs are only shared by the members according to the membership guidelines. Our members agree to the Statement of Beliefs and voluntarily submit monthly contributions into a cost sharing account with Unity HealthShare, acting as a neutral clearing house between members. Organizations like ours have been operating successfully for years. We are including the following caveat for all to consider:

> *This publication or membership is not issued by an insurance company, nor is it offered through an insurance company. This publication or the membership does not guarantee or promise that your eligible medical needs will be shared by the membership. This publication or the membership should never be considered as a substitute for an insurance policy. If the publication or the membership is unable to share in all or part of your eligible medical needs, or whether or not this membership continues to operate, you will remain financially liable for any and all unpaid medical needs.*
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> *This is not a legally binding agreement to reimburse any member for medical needs a member may incur, but is instead, an opportunity for members to care for one another in a time of need and to present their medical needs to other members as outlined in the membership guidelines. The financial assistance members receive will come from other members' monthly contributions that are placed in a sharing account, not from Unity HealthShare.*

(Ex. 11, at p. 3.)

27. The Unity Member Guide also contains a disclaimer that it is not insurance or offered through an insurance company and that whether medical bills may be paid is totally voluntary, pursuant to Georgia law:

Georgia Statute 33-1-20
Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

(Ex. 11, at p. 23.)

28. Further, the Unity Member Guide provides for alternative dispute resolution, including appeals, mediation and arbitration:

DISPUTE RESOLUTION AND APPEAL

Unity HealthShare[SM] is a voluntary association of like-minded people who come together to assist each other by sharing medical expenses. Such a sharing and caring association does not lend itself well to the mentality of legally enforceable rights. However, it is recognized that differences of opinion will occur, and that a methodology for resolving disputes must be available. Therefore, by becoming a Sharing Member of Unity HealthShare[SM], you agree that any dispute you have with or against Unity HealthShare[SM], its associates, or employees will be settled using the following steps of action, and only as a course of last resort.

If a determination is made with which the sharing member disagrees and believes there is a logically defensible reason why the initial determination is wrong, then the sharing member may file an appeal.

A. **1st Level Appeal**. Most differences of opinion can be resolved simply by calling Unity HealthShare[SM] who will try to resolve the matter within ten (10) working days in writing.

B. **2nd Level Appeal.** If the sharing member is unsatisfied with the determination of the member services representative, then the sharing member may request a review by the Internal Resolution Committee, made up of three Unity HealthShare[SM] officials: the needs processing manager, the assistant director, and the executive director. The appeal must be in writing, stating the elements of the dispute and the relevant facts. Importantly, the appeal should address all of the following:

1. What information does Unity HealthShare[SM] have that is either incomplete or incorrect?
2. How do you believe Unity HealthShare[SM] has misinterpreted the information already on hand?
3. Which provision in the Unity HealthShare[SM] Guidelines do you believe Unity HealthShare[SM] applied incorrectly?

Within thirty (30) days, the Internal Resolution Committee will render a written decision.

C. **3rd Level Appeal.** Should the matter remain unresolved, then the aggrieved party may ask that the dispute be submitted to three sharing members in good standing and randomly chosen by Unity HealthShare[SM], who shall agree to review the matter and shall constitute an External Resolution Committee. Within thirty (30) days the External Resolution Committee shall render their opinion in writing.

D. **Final Appeal.** If the aggrieved sharing member disagrees with the conclusion of his/her fellow sharing members, then the aggrieved party may ask that the dispute be submitted to a medical expense auditor, who shall have the matter reviewed by a panel consisting of personnel who were not involved in the original determination and who shall render their opinion in writing within thirty (30) days.

E. **Mediation and Arbitration.** If the aggrieved sharing member disagrees with the conclusion of the Final Appeal Panel, then the matter shall be settled by mediation and, if necessary, legally binding arbitration in accordance with the Rules of Procedure for Christian Conciliation of the Institute for Christian Conciliation, a division of Peacemaker Ministries. Judgment upon an arbitration decision may be entered in any court otherwise having jurisdiction. Sharing members agree and understand that these methods shall be the sole remedy for any controversy or claim arising out of the Sharing Guidelines and expressly waive their right to file a lawsuit in any civil court against one another for such disputes, except to enforce an arbitration decision. Any such arbitration shall be held in Fredericksburg, Virginia, subject to the laws of the Commonwealth of Virginia. Unity HealthShare[SM] shall pay the fees of the arbitrator in full and all other expenses of the arbitration; provided, however, that each party shall pay for and bear the cost of its own transportation, accommodations, experts, evidence, and legal counsel, and provided further that the aggrieved sharing member shall reimburse the full cost of arbitration should the arbitrator determine in favor of Unity HealthShare[SM] and not the aggrieved sharing member. The aggrieved sharing member agrees to be legally bound by the arbitrator's decision. The Rules of Procedure for Christian Conciliation of the Institute for Christian Conciliation, a division of Peacemaker Ministries, will be the sole and exclusive procedure for resolving any dispute between individual members and Unity HealthShare[SM] when disputes cannot be otherwise settled.

(Ex. 11, at p. 17.)

29. Funduk has not completed the dispute resolution process. More specifically, she has not exhausted the various levels of appeal. She has not submitted a request for or participated in mediation. She has not submitted a request for or participated in arbitration.

30. Likewise, as part of her membership in Trinity's HCSM, Funduk received a copy of and agreed to Trinity's Member Guide, among other documents. (*See* Exhibit 12, attached hereto, which is Funduk's Trinity Member Guide.) In conjunction with becoming a Trinity member and after receiving the Trinity Member

Guide, Funduk made voluntary member sharing contributions each month for the period of November 1, 2018 to June 30, 2019.

31. Among other provisions, Funduk's Trinity Member Guide provides within the first few pages a conspicuous disclaimer that membership in Trinity is a faith-based, voluntary sharing membership, and it is not insurance:

DISCLAIMER

AlieraCare offering by Trinity HealthShare, through Aliera Healthcare, Inc., is a faith-based medical needs sharing membership. Medical needs are only shared by the members according to the membership guidelines. Our members agree to the Statement of Beliefs and voluntarily submit monthly contributions into a cost-sharing account with Trinity HealthShare, acting as a neutral clearing house between members. Organizations like ours have been operating successfully for years. We are including the following caveat for all to consider:

> This publication or membership is not issued by an insurance company, nor is it offered through an insurance company. This publication or the membership does not guarantee or promise that your eligible medical needs will be shared by the membership. This publication or the membership should never be considered as a substitute for an insurance policy. If the publication or the membership is unable to share in all or part of your eligible medical needs, or whether or not this membership continues to operate, you will remain financially liable for any and all unpaid medical needs.

> This is not a legally binding agreement to reimburse any member for medical needs a member may incur, but is instead, an opportunity for members to care for one another in a time of need, to present their medical needs to other members as outlined in the membership guidelines. The financial assistance members receive will come from other members' monthly contributions that are placed in a sharing account, not from Trinity HealthShare.

(Ex. 12, at p. 3.)

32. The Trinity Member Guide also contains a disclaimer that it is not insurance or offered through an insurance company and that whether medical bills may be paid is totally voluntary, pursuant to Georgia law:

Georgia Statute 33-1-20

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

(Ex. 12, at p. 46.)

33. Further, the Trinity Member Guide provides for alternative dispute resolution, including appeals, mediation and arbitration:

DISPUTE RESOLUTION AND APPEAL

Trinity HealthShare is a voluntary association of like-minded people who come together to assist each other by sharing medical expenses. Such a sharing and caring association does not lend itself well to the mentality of legally enforceable rights. However, it is recognized that differences of opinion will occur, and that a methodology for resolving disputes must be available. Therefore, by becoming a Sharing Member of Trinity HealthShare you agree that any dispute you have with or against Trinity HealthShare its associates, or employees will be settled using the following steps of action, and only as a course of last resort.

If a determination is made with which the sharing member disagrees and believes there is a logically defensible reason why the initial determination is wrong, then the sharing member may file an appeal.

A. **1st Level Appeal.** Most differences of opinion can be resolved simply by calling Trinity HealthShare who will try to resolve the matter telephonically within a reasonable amount of time.

B. **2nd Level Appeal.** If the sharing member is unsatisfied with the determination of the member services representative, then the sharing member may request a review by the Internal Resolution Committee, made up of three Trinity HealthShare officials. The appeal must be in writing, stating the elements of the dispute and the relevant facts. Importantly, the appeal should address all of the following:

1. What information does Trinity HealthShare have that is either incomplete or incorrect?
2. How do you believe Trinity HealthShare has misinterpreted the information already on hand?
3. Which provision in the Trinity HealthShare Guidelines do you believe Trinity HealthShare applied incorrectly?

Within thirty (30) days, the Internal Resolution Committee will render a written decision, unless additional medical documentation is required to make an accurate decision.

C. **3rd Level Appeal.** Should the matter remain unresolved, then the aggrieved party may ask that the dispute be submitted to three sharing members in good standing and randomly chosen by Trinity HealthShare, who shall agree to review the matter and shall constitute an External Resolution Committee. Within thirty (30) days the External Resolution Committee shall render their opinion in writing, unless additional medical documentation is required to make an accurate decision.

D. **Final Appeal.** If the aggrieved sharing member disagrees with the conclusion of his/her fellow sharing members, then the aggrieved party may ask that the dispute be submitted to a medical expense auditor, who shall have the matter reviewed by a panel consisting of personnel who were not involved in the original determination and who shall render their opinion in writing within thirty (30) days, unless additional medical documentation is required to make an accurate decision.

E. **Mediation and Arbitration.** If the aggrieved sharing member disagrees with the conclusion of the Final Appeal Panel, then the matter shall be resolved by first submitting the disputed matter to mediation. If the dispute is not resolved the matter will be submitted to legally binding arbitration in accordance with the Rules and Procedure of the American Arbitration Association. Sharing members agree and understand that these methods shall be the sole remedy to resolve any controversy or claim arising out of the Sharing Guidelines, and expressly waive their right to file a lawsuit in any civil court against one another for such disputes; except to enforce an arbitration decision. Any arbitration shall be held in Atlanta, Georgia, and conducted in the English language subject to the laws of the State of Georgia. Trinity HealthShare shall pay the filing fees for the arbitration and arbitrator in full at the time of filing. All other expenses of the arbitration shall be paid by each party including costs related to transportation, accommodations, experts, evidence gathering, and legal counsel. Further agreed that the aggrieved sharing member shall reimburse the full costs associated with the arbitration, should the arbitrator render a judgment in favor of Trinity HealthShare and not the aggrieved sharing member.

> The aggrieved sharing member agrees to be legally bound by the arbitrator's final decision. The parties may alternatively elect to use other professional arbitration services available in the Atlanta metropolitan area, by mutual agreement.

(Ex. 12, at pp. 34-35.)

34. Funduk has not completed the dispute resolution process. More specifically, she has not exhausted the various levels of appeal. She has not submitted a request for or participated in mediation. She has not submitted a request for or participated in arbitration.

35. Aliera's business model necessarily involves interstate commerce. For example, LeCann's residence is reflected as in New York; Selimo's residence is reflected as in New Jersey; and Funduk's residence is reflected as in Georgia. They were members of Unity and/or Trinity's HCSM, which was administered by Aliera in Georgia during the relevant time frames. Moreover, it is Aliera's understanding that Trinity is incorporated pursuant to the laws of the State of Delaware, and its principal place of business is in Georgia. It is Aliera's understanding that Unity was incorporated pursuant to the laws of the State of Virginia. Documentation was submitted on behalf of LeCann, Selimo and Funduk from New York, New Jersey, and Georgia (respectively) directly or indirectly to Aliera in Georgia. Payments originated from Georgia and were sent interstate. LeCann, Selimo and Funduk,

residents of New York, New Jersey, and Georgia (respectively) sent share payments to Aliera, in Georgia, on behalf of Unity and/or Trinity.

36. These are but some examples of how Aliera's business necessarily involves interstate commerce and involved interstate commerce with regard to LeCann, Selimo and Funduk. Indeed, during Aliera's business relationship with Unity and its business relationship with Trinity, both Unity and Trinity had or has members throughout the United States.

37. Aliera keeps true and correct records of applications to become members of Unity and Trinity's HCSM, as well as true and accurate records of members' choices to opt-out of membership. Aliera also keeps true and correct records of requests for sharing, membership information (such as the plan(s) that a member chooses to purchase and member guides), payments pursuant to members' plans, information and documents that are sent to Unity and/or Trinity members, both electronically and in hard copy, members' signatures and agreements to join certain programs, and the like. These documents, including all of the Exhibits that are attached to this Declaration, are prepared, signed (as applicable), and maintained in the regular course of the business of Aliera, and it is and was the regular practice of Aliera to prepare, have signed, and maintain such documents. Based on my role and responsibilities with Aliera, I have personal knowledge of the matters set out

herein, as well as access and familiarity with the discussed documents and information.

I declare pursuant to 28 U.S.C. § 1746, under penalty of perjury, that the foregoing is true and correct and based upon my personal knowledge.

Executed this 15th day of July, 2020.

Kathleen Kromodimedjo

KROMODIMEDJO DECLARATION

EXHIBIT 1

Opened: 07/19/2018 - 06:44:57 PM
Email Batch - Batch Member Only

From: info@alierahealth.com
To: noelle@[redacted].com
CC:
BCC:
Subject: Aliera Healthcare - Welcome - ID 673758384
Attachment:

AlieraCare - Individual
BRONZE | SILVER | GOLD

Welcome to your family of healthcare cost sharing. We look forward to serving your healthcare needs. Please read this welcome letter as it contains:

- your member portal login information
- temporary ID card
- other valuable information

As a new member, what are your next steps?

1. Before your plan is effective, become familiar with the benefits of your membership.
- Your AlieraCare Bronze, Silver, Gold Member Guide contains everything you need to know regarding your healthcare plan. To view the PDF version of your Member Guide, please click here.
- The Member Guide booklet is included in your membership kit which will arrive at your mailing address within 14 business days after your plan□s effective date.
- Your temporary card is included below. Please print it and use it until you receive your permanent card in your membership kit.

- Access your Member Portal to view and update your personal or payment information. Go to www.alierahealthcare.com and select Member Login in the navigation menu, and then select Member Portal. Register your account and keep your login information in a safe place for future reference.

2. On or after your effective date (Important: Telemedicine cannot be accessed until on or after your Plan effective date)
- Activate and verify your Membership card: https://www.alierahealthcare.com/members/activation/
- Access your Claims Portal for the ability to manage your information and get answers to provider, claims, and benefit questions. Visit www.alierahealthcare.com and select □Members□ in the top menu bar and select □Login□. Then click □New Member Registration□ to create your login information.
- Complete your registration with FirstCall Telemedicine. Access FirstCall by visiting www.FirstCallTelemed.com to register your account or call 1-866-920-DOCS (1-866-920-3627) for assistance. Click here for instructions. FirstCall Telemedicine login information is not provided, please complete registration to obtain login information.
- Complete your registration with Rx Valet □ Pharmacy Program. Access Rx Valet by visiting www.MyRxValet.com/memberlogin.php. Enter your Aliera Member ID, and Group ID (Aliera). Complete your profile for yourself and then add your dependents. If you encounter any difficulties, please call 855-798-2538.

3. Using your benefits
- Until you receive your permanent ID card, use the temporary card. Your membership is active and you can immediately begin to take advantage of your benefits.
- If you have a medical emergency, call 911.
- If you are in need of prescription medications, log into your Rx Valet account at www.MyRxValet.com and Pre-Purchase your medication. You will be texted an electronic Benefit Card that you will present at the pharmacy. No co-pay will be required. Additional pharmacy discount

details are located on your card.
- For individual plans, you may contact your provider to schedule an appointment, or you may call Unity□s Concierge line at 877-649-7466 for assistance. You can also request an appointment at http://www.alierahealthcare.com/appointments/

At the core of our Healthcare Sharing Ministry is our Statement of Beliefs. If you do not or did not agree with the Statement of Beliefs below, please let us know and we will be happy to answer any of your questions or help you understand what it is like to be a member of Unity HealthShare.

Below is a review of the Statement of Beliefs you have agreed to:

1. We believe that our personal rights and liberties originate from God and are bestowed on us by God.

2. We believe every individual has a fundamental religious right to worship God in his or her own way.

3. We believe it is our moral and ethical obligation to assist our fellow man when they are in need according to our available resources and opportunity.

4. We believe it is our spiritual duty to God and our ethical duty to others to maintain a healthy lifestyle and avoid foods, behaviors or habits that produce sickness or disease to ourselves or others.

5. We believe it is our fundamental right of conscience to direct our own healthcare, in consultation with physicians, family or other valued advisors.

Notice: This publication is not issued by an insurance company nor is it offered through an insurance company. It does not guarantee or promise that your medical bills will be published or assigned to others for payment. No other subscriber will be compelled to contribute toward the cost of your medical bills. Therefore, this publication should never be considered a substitute for an insurance policy. This activity is not regulated by the State Insurance Administration, and your liabilities are not covered by the Life and Health Guaranty Fund. Whether or not you receive any payments for medical expenses and whether or not this entity continues to operate, you are always liable for any unpaid bills.

Member Care

Our friendly and highly experienced staff is ready to help you with all your questions and concerns about your membership. Whether you have a question regarding your services, need assistance, or have a special request contact a Member Services Representative at (844) 834-3456, Monday through Friday from 8:00 AM until 8:00 PM, Eastern Time, or by email at memberservices@alierahealthcare.com.

Order Information

Please review the information below to ensure all details are correct. If you need to make any changes please call Member Care.

Product: AlieraCare Gold - Individual plus 1 Dependent
Order Date: July 19, 2018
Effective Date: August 1, 2018
Amount Paid: $1,484.47 - July 19, 2018 - Credit Card - SALE - Approved - Payment 1 - Completed - - - [redacted] - 107234 - Products: AlieraCare Gold (20726)

*The entry on your bank or credit card statement for your healthcare payments is □Aliera Healthcare□.

Member Information

ID: 673758384
Name: Noelle Lecann

Address:
City: New York
State: NY
Zip Code: 10003-4685
Day Phone: (212)
Email: noelle@ s.com

Richard Fronapfel - Spouse - M -

Your Temporary ID Card
Until you receive your permanent Member Card in the mail, please print and use the temporary card shown below.

[Front of Card]

AlieraCare - Individual
BRONZE | SILVER | GOLD

Member Services: 800-847-9794
Telemedicine: 866-920-3627
Pharmacy: 855-798-2538
Eligibility: 800-847-9794

Effective Date: 08/01/2018
Plan ID: AlieraCareGold
MSRA*: 1000
Primary: Noelle Lecann
Primary ID: 673758384
Dependents: Richard Fronapfel

Hospital: YES
In-Patient: YES
Out-Patient: YES

ER: Verify Eligibility
Specialty: Verify Eligibility

Rx Valet Pharmacy Services
855-798-2538
www.MyRxValet.com

Additional Pharmacy Services
Group: 2504
BIN #: 006053
PCN: SS
ID: 2504415687

This participant and any listed dependents are Members of a Health Care Sharing Ministry recognized pursuant to 26 USC § 5000A(d)(2)(B) that does not engage in the business of insurance. Members make monthly contributions that are used to voluntarily pay each other□s medical expenses based on a shared set of ethical or religious beliefs.
*MSRA = Member Shared Responsibility Amount

Verify eligibility for payment: 800-UHS-9794 (800-847-9794)

[Backside of Card]

Member Services: 800-847-9794
Telemedicine: 866-920-3627

Pharmacy: 855-798-2538
Eligibility: 800-847-9794

Mail claims forms to:
Aliera Healthcare Unity
P.O. Box 16818
Lubbock, TX 79490-6818
or EDI # : ALH01 | 1-800-252-3684

AlieraCare Individual | Bronze, Silver & Gold Plans*
PROVIDER should verify eligibility before providing treatment or service.

PHCS (logo)
Visit multiplan.com or
call 800-922-4362 for your PHCS provider.

PCP Visit:
Bronze: $50
Silver: $35
Gold: $20

Urgent Care Visit:
Bronze: $100
Silver: $75
Gold: $75

Emergency Room:
Bronze: $500
Silver: $300
Gold: $150

Specialty Visit:
Bronze: $125
Silver: $75
Gold: $75

Preventive: $0

X-Ray and Imaging:
Bronze: 60% after MSRA
Silver: 70% after MSRA
Gold: 80% after MSRA

MSRA = Member Shared Responsibility Amount | * Consult fees shown are in-network rates.
www.alierahealthcare.com | www.unityhealthshare.org

[End of Card]

Thank you,

The Aliera Healthcare Team.

Disclosure, Terms and Conditions

To view a copy of the Disclosure Statement and Terms and Conditions, click below:
https://www.alierahealth.com/media/1246/Individual%20Terms_Conditions_Authorization%20Agreement.pdf

Aliera Healthcare follows CMS (Centers for Medicare and Medicaid Services) guidelines for recommended preventive care required by the ACA. Aliera also recognizes the U.S. Preventive Services Task Force (USPSTF) for recommended screenings, physicals, frequency of care, etc. To

view your USPSTF A and B Recommendations, click below:
https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

ALIERACARE™
BRONZE | SILVER | GOLD

Welcome to your family of healthcare cost sharing. We look forward to serving your healthcare needs. Please read this welcome letter as it contains:

- your member portal login information
- temporary ID card
- other valuable information

As a new member, what are your next steps?

1. **Before your plan is effective, become familiar with the benefits of your membership**.
    - Your AlieraCare Bronze, Silver, Gold Member Guide contains everything you need to know regarding your healthcare plan. To view the PDF version of your Member Guide, please click here.
    - The Member Guide booklet is included in your membership kit which will arrive at your mailing address within 14 business days *after your plan's effective date.*
    - Your temporary card is included below. Please print it and use it until you receive your permanent card in your membership kit.
    - Access your Member Portal to view and update your personal or payment information. Go to www.alierahealthcare.com and select Member Login in the navigation menu, and then select Member Portal. *Register your account and keep your login information in a safe place for future reference.*
2. **On or after your effective date** *(**Important**: Telemedicine **cannot** be accessed until **on or after** your Plan effective date)*
    - ***Activate and verify your Membership card.*** Click here for instructions.
    - ***Access your Claims Portal*** for the ability to manage your information and get answers to provider, claims, and benefit questions. Visit www.alierahealthcare.com and select "Members" in the top menu bar and select "Login". Then click "New Member Registration" to create your login information.
    - ***Complete your registration with FirstCall Telemedicine***. Access FirstCall by visiting www.FirstCallTelemed.com to register your account or call 1-866-920-DOCS (1-866-920-3627) for assistance. Click here for instructions. **FirstCall Telemedicine login information is not provided, please complete registration to obtain login information**.
    - ***Complete your registration with Rx Valet – Pharmacy Program. Access Rx Valet by visiting www.MyRxValet.com/memberlogin.php.*** *Enter your Aliera Member ID, and Group ID (**Aliera**). Complete your profile for yourself and then add your dependents. If you encounter any difficulties, please call 855-798-2538.*
3. **Using your benefits**

- Until you receive your permanent ID card, use the temporary card. Your membership is active and you can immediately begin to take advantage of your benefits.
- If you have a medical emergency, call 911.
- If you are in need of prescription medications, log into your Rx Valet account at www.MyRxValet.com and Pre-Purchase your medication. You will be texted an electronic Benefit Card that you will present at the pharmacy. No co-pay will be required. Additional pharmacy discount details are located on your card.
- For individual plans, you may contact your provider to schedule an appointment, or you may call Unity's Concierge line at 877-649-7466 for assistance. You can also request an appointment at http://www.alierahealthcare.com/appointments/

At the core of our Healthcare Sharing Ministry is our Statement of Beliefs. If you do not or did not agree with the Statement of Beliefs below, please let us know and we will be happy to answer any of your questions or help you understand what it is like to be a member of Unity HealthShare.

Below is a review of the *Statement of Beliefs* you have agreed to:

1. We believe that our personal rights and liberties originate from God and are bestowed on us by God.

2. We believe every individual has a fundamental religious right to worship God in his or her own way.

3. We believe it is our moral and ethical obligation to assist our fellow man when they are in need according to our available resources and opportunity.

4. We believe it is our spiritual duty to God and our ethical duty to others to maintain a healthy lifestyle and avoid foods, behaviors or habits that produce sickness or disease to ourselves or others.

5. We believe it is our fundamental right of conscience to direct our own healthcare, in consultation with physicians, family or other valued advisors.

Notice: This publication is not issued by an insurance company nor is it offered through an insurance company. It does not guarantee or promise that your medical bills will be published or assigned to others for payment. No other subscriber will be compelled to contribute toward the cost of your medical bills. Therefore, this publication should never be considered a substitute for an insurance policy. This activity is not regulated by the State Insurance Administration, and your liabilities are not covered by the Life and Health Guaranty Fund. Whether or not you receive any payments for medical expenses and whether or not this entity continues to operate, you are always liable for any unpaid bills.

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Our friendly and highly experienced staff is ready to help you with all your questions and concerns about your membership. Whether you have a question regarding your services, need assistance, or have a special request contact a Member Services Representative at (844) 834-3456, Monday through Friday from 8:00 AM until 8:00 PM, Eastern Time, or by email at memberservices@alierahealthcare.com.

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Please review the information below to ensure all details are correct. If you need to make any changes please call Member Care.

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Order Date: July 19, 2018
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*The entry on your bank or credit card statement for your healthcare payments is "Aliera Healthcare".

Member Information

ID: 673758384
Name: Noelle Lecann
Address: [redacted]
City: New York
State: NY
Zip Code: 10003-4685
Day Phone: (212) [redacted]

Email: noelle@alphasourceadvisors.com

Richard Fronapfel - Spouse - M - [redacted]

Your Temporary ID Card

Until you receive your permanent Member Card in the mail, please print and use the temporary card shown below.

ALIERACARE BRONZE | SILVER | GOLD — PHCS		Effective Date: 08/01/2018 Plan ID: AlieraCareGold MSRA*: 1000
Primary: Noelle Lecann Primary ID: 673758384 Dependents: Richard Fronapfel	Hospital: YES In-Patient: YES Out-Patient: YES	ER: Verify Eligibility Specialty: Verify Eligibility
	Rx Valet 855-798-2538 www.MyRxValet.com	**Additional Pharmacy Services** Group: 2504 BIN #: 006053 PCN: SS ID: 2504415687
This participant and any listed dependents are Members of a Health Care Sharing Ministry recognized pursuant to 26 USC § 5000A(d)(2)(B) that does not engage in the business of insurance. Members make monthly contributions that are used to voluntarily pay each other's medical expenses based on a shared set of ethical or religious beliefs. ***MSRA** = Member Shared Responsibility Amount		
Verify eligibility for payment: 800-UHS-9794 (800-847-9794)		

UNITY HEALTHSHARE / FirstCall Telemedicine	**Mail claims forms to:** Aliera Healthcare Unity P.O. Box 16818 Lubbock, TX 79490-6818 or EDI # : ALH01 | 1-800-252-3684	Member Services: 800-847-9794 Telemedicine: 866-920-3627 Pharmacy: 855-798-2538 Eligibility: 800-847-9794
PROVIDER should verify eligibility before providing treatment or service.		

AlieraCare Individual | Bronze, Silver & Gold Plans*			
PCP Visit: Bronze: $50 Silver: $35 Gold: $20 Urgent Care Visit: Bronze: $100 Silver: $75 Gold: $75	Emergency Room: Bronze: $500 Silver: $300 Gold: $150 Specialty Visit: Bronze: $125 Silver: $75 Gold: $75	Preventive: $0 X-Ray and Imaging: Bronze: 60% after MSRA Silver: 70% after MSRA Gold: 80% after MSRA	**Visit multiplan.com or call 800-922-4362 for your PHCS provider.**
MSRA = Member Shared Responsibility Amount | * Consult fees shown are in-network rates.			
www.alierahealthcare.com | www.unityhealthshare.org			

Thank you,

The Aliera Healthcare Team.

Disclosure, Terms and Conditions

To view a copy of the Disclosure Statement and Terms and Conditions, click here.

Aliera Healthcare follows CMS (Centers for Medicare and Medicaid Services) guidelines for recommended preventive care required by the ACA. Aliera also recognizes the U.S. Preventive Services Task Force (USPSTF) for recommended screenings, physicals, frequency of care, etc. To view your USPSTF A and B Recommendations, click here.

KROMODIMEDJO DECLARATION

EXHIBIT 2

ALIERA™ HEALTHCARE

Plan Update Authorization Form

Important Information About Your Plan Update:

Aliera is no longer selling your current healthcare plan with Unity HealthShare, LLC component. We do have a new plan available through our alliance with Trinity HealthShare that offers the same plan services and benefits.

Plus, the following track with each member:

- Medical history and historical claims
- Payments toward member shared responsibility amount (MSRA)
- Time spent on the plan

Member Information:

Last Name: LeCann	First Name: Noelle-Claire	MI:	Date of Birth:
Member ID: 673758384			

Acknowledgement:

I hereby authorize Aliera Healthcare to change my current Aliera/Unity plan to an equivalent Aliera/Trinity plan and receive the first month's payment will be waived.

I, the Primary Account Holder, understands and agrees to all fees, regulations, and limitations of the above said plan. Effective the next billing cycle, I understand that my coverage on the existing plan will be terminated, and coverage on the new plan will initiate.

Signature: DocuSigned by: Noelle-Claire LeCann B24360242CD34A3...	Printed Name: Noelle-Claire LeCann
Date: 05/13/2019	

KROMODIMEDJO DECLARATION

EXHIBIT 3

ALIERA™ HEALTHCARE

Individual Member Cancellation Form

Member Information:

Last Name: LeCann	First Name: Noelle-Claire	MI:	Date of Birth: [redacted]
Sex: ✓ Female ☐ Male	Member ID: 673758384	Today's Date: 11/18/2019	
Street Address: [redacted]			
City: Bayside	State: NY	Zip Code: 11361	

Plan Cancellation:

I am canceling this plan because the member is:

- ☐ Deceased
- ✓ Dissatisfied with service
- ☐ Purchasing a different plan
- ☐ Moving out of the area
- ☐ Terminated from employment
- ☐ Other, please specify

Authorization:

Member authorizes the cancellation/change of the above named member's membership.

- Member understands and agrees that the current monthly membership fee payment entitles Member to receive health benefit services until the end of the current term.
- Member understands that as of the end of the membership, Member will not be able to access any of the services offered by Aliera Healthcare.

Signature: Noelle-Claire LeCann Printed Name: Noelle-Claire LeCa

Date: 11 / 18 / 2019 SIGNATURE BY: ✓ Member ☐ Parent ☐ Legal Guardian

Email to: cancellation@alierahealthcare.com

Forms can also be faxed to 478-787-0010

HELLOSIGN

Audit Trail

TITLE	Noelle Lecann
FILE NAME	Cancellation_Form_Mar_2019.pdf
DOCUMENT ID	0d22c11987608b7bd5ed5f372bdadccde92bb831
AUDIT TRAIL DATE FORMAT	MM / DD / YYYY
STATUS	Completed

Document History

SENT	**11** / **18** / **2019** 11:58:48 UTC-5	Sent for signature to Noelle Lecann (noelle@alphasourceadvisors.com) from edwin.munevar@alieracompanies.com IP: 170.199.233.166
VIEWED	**11** / **18** / **2019** 12:05:37 UTC-5	Viewed by Noelle Lecann (noelle@alphasourceadvisors.com) IP: 98.0.245.234
SIGNED	**11** / **18** / **2019** 12:09:28 UTC-5	Signed by Noelle Lecann (noelle@alphasourceadvisors.com) IP: 98.0.245.234
COMPLETED	**11** / **18** / **2019** 12:09:28 UTC-5	The document has been completed.

KROMODIMEDJO DECLARATION

EXHIBIT 4

MEMBER GUIDE

ALIERA™ Healthcare

INDIVIDUAL/FAMILY

5901 Peachtree Dunwoody Road, Suite B-200
Atlanta, GA 30328
Toll-Free 844-834-3456
www.alierahealthcare.com

ALIERACARE™
BRONZE | SILVER | GOLD

UNITY™ HEALTHSHARE

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AlieraCare Plans are NOT Insurance.

CONTENTS

MEMBER GUIDE

WELCOME

Welcome to Aliera Healthcare, Inc. | Unity Healthshare, LLC. Thank you for becoming a member. We are committed to providing you and your family with unparalleled service and care at an affordable cost, and we pledge to keep our focus on what's most important – your overall health and wellness.

Please take a few minutes to review the information in this guide. The more informed you are, the easier it will be to get the care you need when you need it the most. Your membership card(s) and this booklet provide important information about your Plan, as well as the steps you need to take to access healthcare at one of the thousands of participating network provider locations. Your welcome information, Member Portal access and temporary member cards are contained in your Welcome Email: please print it and save a copy for reference.

If you have any questions about your Plan, activating your Membership Card, setting up your telemedicine account, Rx discount program, or accessing a healthcare provider, please contact a Member Care Specialist for assistance, **Monday through Friday, 8 a.m. to 8 p.m. ET at (844) 834-3456.**

Member Portal

Username and password credentials are needed to enter the Member's portal to update payment or personal information. Visit www.AlieraHealthcare.com and click the Member Login tab. Your user name and password are on the Welcome Email sent at the time of initial enrollment. Member Services can send you a copy of this email following confirmation of identity.

Contact Information

For general information, account management, monthly contribution, or medical needs, please contact us:

Phone: 844-834-3456

Fax: 404-937-6557

Email: memberservices@alierahealthcare.com or memberservices@unityhealthshare.org

Online: www.alierahealthcare.com or www.unityhealthshare.org

Mail: 5901 Peachtree Dunwoody Road, Suite B-200 Atlanta, Georgia 30328

Disclaimer

AlieraCare offering by Unity Healthshare, LLC, through Aliera Healthcare, Inc., is a faith-based medical needs sharing membership. Medical needs are only shared by the members according to the membership guidelines. Our members agree to the Statement of Beliefs and voluntarily submit monthly contributions into a cost sharing account with Unity Healthshare, LLC, acting as a neutral clearing house between members. Organizations like ours have been operating successfully for years. We are including the following caveat for all to consider:

> This publication or membership is not issued by an insurance company, nor is it offered through an insurance company. This publication or the membership does not guarantee or promise that your eligible medical needs will be shared by the membership. This publication or the membership should never be considered as a substitute for an insurance policy. If the publication or the membership is unable to share in all or part of your eligible medical needs, or whether or not this membership continues to operate, you will remain financially liable for any and all unpaid medical needs.
>
> This is not a legally binding agreement to reimburse any member for medical needs a member may incur, but is instead, an opportunity for members to care for one another in a time of need, to present their medical needs to other members as outlined in the membership guidelines. The financial assistance members receive will come from other members' monthly contributions that are placed in a sharing account, not from Unity Healthshare, LLC.

PLAN SERVICES & MEMBERSHIP AT A GLANCE

Aliera Healthcare, Inc. services in conjuction with Unity Healthshare, LLC cost sharing creates a full range of services and benefits, each part summarized below:

Preventive Care

As part of our solution, the plans cover medical services recommended by the USPSTF and outlined in the ACA for preventive care. There is zero out of pocket expense and zero obligation to reach the Member Shared Responsibility Amount (MSRA) for any scheduled preventive care service or routine in-network check-up, pap smear, flu shot and more. It's easier to stay healthy with regular preventive care.

Episodic Primary Care

Primary care is at the core of an Aliera Plan, and we consider it a key step in living a healthier lifestyle. Our model is based on an innovative approach to care that is truly patient-centered, combining excellent service with a modern approach. This includes medical care needs such as primary care, office visits, sick care, and the general care of a member's day to day medical needs.

Chronic Maintenance

With an AlieraCare Bronze, Silver, or Gold plan, members are eligible to receive chronic care management from your primary care physician for conditions such as diabetes, asthma, blood pressure, cardiac conditions, etc.

Labs & Diagnostics

Labs at in-network facilities are included.

Telemedicine

With full 24/7 365-day access to a board-certified physician, it has never been simpler to stay healthy. You can contact them easily by phone or via video chat. If it's something minor such as a sinus infection, poison ivy or pink eye they can even send a prescription right over to your pharmacist.

Prescription Drug Program

The AlieraCare Bronze, Silver, or Gold prescription savings program delivers significant discounts for a variety of drugs (depending on prescription), saving members an average of 55% on prescription drug purchases. After $1,500 of prescription drug expenditures through Rx Valet, members are eligible for a percentage of reimbursement for preferred and mail order drugs. Maximum reimbursement of $4,000 per plan year. See Appendix for details.

Urgent care

For those medical situations that can't wait or are more complex than primary care services, AlieraCare Bronze, Silver, and Gold plans offer access to Urgent Care facilities at hundreds of medical centers throughout the United States.

PLAN SERVICES & MEMBERSHIP AT A GLANCE

Membership

Unity Healthshare, LLC is a health care sharing ministry (HCSM) which acts as an organizational clearing house to administer sharing contributions across qualifying members healthcare needs. The AlieraCare membership is NOT health insurance. The membership is based on a religious tradition of mutual aid, neighborly assistance, and burden sharing. The membership does not subsidize self-destructive behaviors and lifestyles, but is specifically tailored for individuals who maintain a healthy lifestyle, make responsible choices in regards to health and care, and believe in helping others. Because Unity Healthshare, LLC is a religious organization, members are required to agree with the organizations Statement of Beliefs; see Part II of this guide for the full description and membership details.

Specialty Care

For most everyday medical conditions, your PCP is your one-stop medical shop. However, there are cases when it's time to see a specialist who's had additional education and been board certified for that specialty. For situations like these, the AlieraCare Bronze, Silver, and Gold plans provides specialty care benefits at the cost of just a consult fee. A member will need to receive a PCP referral to see a specialist for treatment or consultation outside of their scope of knowledge.

Hospitalization

Hospitalization is eligible, once the Member Shared Responsibility Amount has been met, under all the individual plans.

Surgery

Both in-patient and out-patient procedures are eligible, once the Member Shared Responsibility Amount has been met, under all individual plans.

Emergency Room

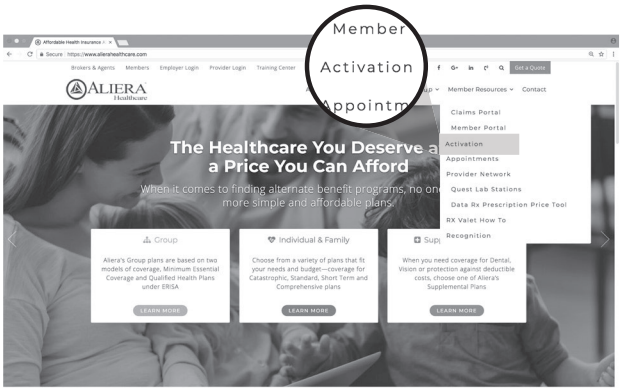
An emergency is defined as treatment that must be rendered to the patient immediately for the alleviation of the sudden onset of an unforeseen illness or injury that, if not treated, would lead to further disability or death. Examples of an emergency include, but are not limited to, severe pain, choking, major bleeding, heart attack, or a sudden, unexplained loss of consciousness.

UNITY HEALTHSHARE

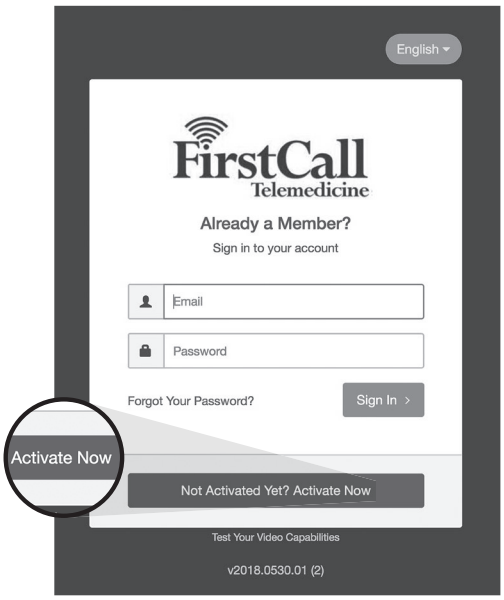
GETTING STARTED

What does it mean? Many of the terms used in describing health cost sharing may be unfamiliar to those new to the programs and plans provided by Aliera and Unity. Please refer to the Definition of Terms section for a quick and easy understanding of terms used in this guide and other plan documents.

1. **Activate Your Membership**
   On or after your effective date, visit www.alierahealthcare.com to securely enter your information. Click the Activate tab on the navigation bar and follow the instructions.
   If you require assistance, contact a Member Care Specialist toll-free at (844) 834-3456 or email memberservices@alierahealthcare.com.



2. **Set Up Your Telemedicine Account**
   Follow the steps below to set up your telemedicine account. If you have not activated your Membership Card, or if your Membership fees are not paid up to date, you are not eligible to set up your telemedicine account.
   - Set up your account (Primary Member)
     Visit www.firstcalltelemed.com, Click "Set up account." Follow the online instructions and provide the required information, including your medical history.



- Set up minor dependents (17 years or younger)
  Log in to your account and click “My Family” on the top menu. Follow the online instructions to provide the necessary information and complete your dependent’s medical history.
- Set up adult dependents (18 – 26 years)
  Adult dependents must set up their own account. Visit the website and click “Set up account.” Follow the online instructions to provide the required information and to complete your medical history.

3. **Set Up your Prescription Discount Account**
   Follow the steps below to set up your prescription discount account. If you have not activated your Membership Card, or if your Membership fees are not paid up to date, you are not eligible to set up your prescription discount account.

Please go to www.myrxvalet.com/memberlogin.php

1. Enter your Member ID that is located on your Aliera Healthcare ID card
2. For your Group ID type in Aliera
3. Complete your profile for yourself and any dependents

After registration is complete, you will receive an email with instructions and a video on how to use Rx Valet for home delivery and at your local pharmacy.

Please download the Rx Valet APP on your smartphone at your convenience.

If you are experiencing an urgent situation and don't have time to set up your account, you can hand your Aliera card to the pharmacist to receive your medication. The discount will not be as great, so please set up your account when you have time.

Home Delivery Prescription Information:

- Home Delivery orders are fulfilled exclusively through Advanced Pharmacy, LLC. To save time, have your physician send your prescription directly to Advanced Pharmacy electronically.
- Alternatively, they can also transfer your existing prescriptions from another pharmacy to fulfill your order. Please call their live Customer Care Team at 1-855-798-2538 and provide the medication details, pharmacy name, and pharmacy telephone number.
- Electronic prescriptions should be sent to **Advanced Pharmacy, LLC located at 350-D Feaster Road Greenville, SC 29615.**

Phone: 855-240-9368 **Fax:** 888-415-7906
NPI: 1174830475 **NCPDP:** 4229971

3. **REVIEW YOUR BENEFITS**
   This guide contains the information you need to understand each benefit available with your Plan. Keep your Member Card with you at all times; the contact number for your telemedicine provider is printed on your card. You must always contact your telemedicine provider before seeking medical attention.

PART I

How to Use Your Membership

The Telemedicine Program

More than 80% of primary medical conditions can be resolved by your telemedicine provider. Members should contact their telemedicine provider first for quick, convenient medical assistance. The contact information for your telemedicine provider is found on your member card. Instructions are also found on the back of your Welcome Letter, as well as on our web site, under Member Resources.

Benefits of the Telemedicine Program

- At home, at work, or while traveling in the US, speak to a telemedicine doctor from anywhere, anytime, on the go.
- 24/7 access to a doctor via face-to-face internet consultation or by phone is available for you and dependents on your Plan.
- Speak with the next available doctor or schedule an appointment for a more convenient time.
- Telemedicine doctors typically respond within 15 minutes of your call.
- Save time and money by avoiding expensive emergency room visits, waiting for an appointment, or driving to a local facility.
- Telemedicine consultations are free for you and dependents on your Plan.
- Telemedicine providers can treat conditions such as:
  - ► Cold and flu symptoms
  - ► Bronchitis
  - ► Allergies
  - ► Poison ivy
  - ► Pink eye
  - ► Urinary tract infections
  - ► Respiratory infections
  - ► Sinus problems
  - ► Ear infections, and more

Antibiotics are not always the answer to treat a medical condition. Doctors may choose not to prescribe antibiotics for viral illnesses such as common colds, sore throats, coughs, sinus infections, and the flu.

If the telemedicine doctor recommends that you see your PCP or visit an urgent care facility, contact Aliera's Concierge Service, and a member care specialist will be happy to assist you with scheduling an appointment.

PREVENTIVE CARE

It's easier to stay healthy when you have regular preventive care. Members have no out-of-pocket expenses for preventive services, which include, but are not limited to, routine in-network checkups, pap smears, flu shots and more.

How to Use Preventive Care Services

1. Download the Preventive Healthcare Guidebook from the link found in your Welcome email or visit us online at www.AlieraHealthcare.com. or www.unityhealthshare.com
2. Members do not need to call their telemedicine provider to schedule preventive care.
3. Upon arrival at a PCP, please present your Membership Card and one photo ID. The front desk admin will check your eligibility status. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not share the costs of the provider.
4. Preventive health services must be appropriate for the eligible person and follow the guidelines below:
   - A) In general – those of the U.S. Preventive Services Task Force that have an A or B rating.
   - B) For immunizations – those of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
   - C) For preventive care and screenings for children and adolescents – those of the Health Resources and Services Administration.
   - D) For preventive care and screenings for women – those of the Health Resources and Services Administration that are not included in section (A) of the U.S. Preventive Services Task Force schedule.

Labs and Diagnostics

Aliera and Unity Members have access to lab work in the convenience of their in-network provider's office or at any lab location nationwide.

URGENT CARE

Your membership raises the standard of healthcare available to you by putting individuals first, treating them with clinical excellence, and focusing on their well-being. Members can access services from hundreds of Urgent Care network facilities throughout the United States.

- AlieraCare Bronze, Silver, and Gold plans have unlimited urgent care visits..
- See Appendix for your specific plan details.
- X-rays are included, and subject to $25 per read fee at Urgent Care.

How to Use the Urgent Care Service

1. Call 911 if your emergency is life threatening; otherwise, please contact your telemedicine provider first via telephone or a scheduled face-to-face internet conference. Your provider will determine if your medical condition can be resolved without visiting a local urgent care facility.
2. If your medical issue cannot be resolved after your free consultation with a telemedicine doctor, visit the closest in-network Urgent Care facility.
3. Upon arrival at an Urgent Care facility, present your Membership Card and one photo ID. The front desk admin will check your eligibility status. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the provider.
4. At time of service, payment of $20 (on average) is due for the consultation, and a $25 per read fee for X-rays if needed may be due. Costs may be higher depending on your state and provider.

If Urgent Care Services are Unavailable

If an Urgent Care facility in the network is unavailable to a Member requiring immediate urgent care, please adhere to the following procedure:

1. Visit www.alierahealthcare.com. Click “Network” to find the nearest urgent care facility under MultiPlan.
2. If the nearest in-network facility is more than 20 miles away from the Member, is closed (after 6:00 p.m.), or is no longer in business, the Member should seek out the nearest Urgent Care facility or hospital emergency room to receive urgent medical attention.

PRIMARY CARE

3. AlieraCare products are not health insurance plans and Aliera nor Unity are responsible for payment to out-of-network Urgent Care or hospital emergency room facilities. The Member is solely responsible for such urgent care medical payments. Aliera and or Unity maintain an allotment fund designed to provide a Member with supplemental payment assistance (ex gratia) in the amount of $105.00 to offset the cost incurred at an out-of-network Urgent Care or Hospital emergency room facility. This monetary assistance is limited to one visit per year, per Member. Payment is made directly to the Member after confirmation of submitted proof of urgent care necessity and unavailability of an in-network provider.

Primary Care For Sick Care

In addition to our urgent care services, many of our plans offer Members under the age of 65 episodic primary care or sick care.

- AlieraCare Bronze, Silver, and Gold plans have unlimited primary care visits.
- Annual Physicals are available immediately.
- For convenience, some clinics are open evenings and weekends.

How to Use Primary Care Service for Sick Care

1. Contact your telemedicine provider to speak with a U.S. board-certified doctor via telephone or a scheduled face-to-face internet conference.
2. The telemedicine doctor may be able to resolve your medical issue and prescribe medication if needed. More than 80% of primary medical conditions can be resolved by your telemedicine provider.
3. If your medical issue cannot be resolved after a no fee consultation with the telemedicine doctor, visit the closest in-network primary care facility.
4. Upon arrival at a clinic, present your Membership Card and one photo ID. The front desk admin will check your eligibility status before you can see a provider. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the provider.
5. At the time of service, a consult fee is due for the consultation, and a $25 per read fee for X-rays if needed. Costs may be higher depending on your state and provider.

SPECIALTY CARE

Specialty Care

AlieraCare members are required to obtain referrals to visit a specialist, except for women in need of gynecological care for routine medical needs. Specialty visits have a consult fee at the time of service.

Hospitalization

Your hospitalization cost-sharing is provided to you in an effort to alleviate the stress and strain during times of crisis or medical needs.

1. Members are required to pre-authorize all hospitalization services and visits unless it is an obvious medical emergency. Please see pre-authorization section for instructions
2. The member will be responsible for first reaching their MSRA before any cost sharing will be available. Once the MSRA has been reached in full, the sharing will then be reimbursed directly back to the providers and hospital facilities.
3. Several plans allow for fixed cost sharing in the emergency room. Please see Appendix A for your exact plan details.

PPO Network

With a growing nationwide PPO network of more than 1,000,000 healthcare professionals and more than 6,000 facilities, Multiplan PHCS network offers Plan Members a range of quality choices to help them stay healthy.

- Search for providers by distance, cost efficiency, and specialty.

Find a Network Healthcare Professional

- Visit **www.alierahealthcare.com**
- Hover over the Member Resources tab
- Click Provider Network
- Click on the Medical Provider logo associated with your plan.
- Search for a provider by Zip Code, City, County, State, or other search criteria.

Call Aliera Healthcare at (844) 834-3456 or Unity Healthshare, LLC at (800)-847-9794. Select the Provider Coordination Department and a care coordinator will help you navigate the healthcare process effectively and efficiently.

PART II

How Your Healthcare Cost Sharing Ministry (HCSM) Works

Membership Overview

Unity Healthshare, LLC is a clearing house that administers voluntary sharing of healthcare needs for qualifying members. The membership is based on a tradition of mutual aid, neighborly assistance, and burden sharing. The membership does not subsidize self-destructive behaviors and lifestyles, but is specifically tailored for individuals who maintain a healthy lifestyle, make responsible choices in regards to health and care, and believe in helping others. The Unity Healthshare, LLC membership is not health insurance.

Guidelines Purpose and Use

The HCSM guidelines are provided as an outline for eligible needs in which contributions are shared in accordance with the membership's clearing house instructions. They are not for the purpose of describing to potential contributors the amount that will be shared on their behalf and do not create a legally enforceable right on the part of any contributor. Neither these guidelines nor any other arrangement between contributors and Unity Healthshare, LLC creates any rights for any contributor as a reciprocal beneficiary, as a third-party beneficiary, or otherwise.

The edition of the guidelines in effect, on the date of medical services, supersedes all previous editions of the guidelines and any other communication, written or verbal. With written notice to the general membership, the guidelines may change at any time based on the preferences of the membership and on the decisions, recommendations, and approval of the Board of Trustees.

An exception to a specific provision only modifies that provision and does not supersede or void any other provisions.

Individuals Helping Individuals

Contributors participating in the membership help individuals with their medical needs. Unity Healthshare, LLC facilitates in this assistance and acts as an independent and neutral clearing house, dispersing monthly contributions as described in the membership instructions and guidelines.

MEMBERSHIP QUALIFICATIONS

To become and remain a member of Unity Healthshare, LLC, a person must meet the following criteria:

Religious Beliefs and Standards. The person must have a belief of helping others and/or maintaining a healthy lifestyle as outlined in the Statement of Beliefs contained in the membership application. If at any time during participation in the membership, the individual is not honoring the Statement of Beliefs, they will be subject to removal from participating in the membership.

Medical History. The person must meet the criteria to be qualified for a membership on his/her application date, based on the criteria set forth in this guidebook and the membership application.

If, at any time, it is discovered that a member did not submit a complete and accurate medical history on the membership application, the criteria set forth in the Membership Eligibility Manual on his/her application date will be applied, and could result in either a retroactive membership limitation or a retroactive denial to his/her effective date of membership.

Members may apply to have a membership limitation removed by providing medical evidence that they qualify for such removal according to the criteria set forth in the Membership Eligibility Manual. Membership limitations and denials can be applied retroactively but cannot be removed retroactively.

Application, Acceptance, and Effective Date. A person must submit a membership application and be accepted into the membership by meeting the criteria of the Member Eligibility Manual. The membership begins on a date specified by Unity Healthshare, LLC in writing to the member.

Dependent(s). A dependent may participate under a combined membership with the head of household.

A dependent wishes to continue participating in the membership but no longer qualifies under a combined membership must apply and qualify for a membership based on the criteria set forth in the Membership Eligibility Manual.

Under a combined membership, the head of household is responsible for ensuring that everyone participating under the combined membership meets and complies with the Statement of Beliefs and all guideline provisions.

Financial Participation. Monthly contributions are requested to be received by the 1st or 15th of each month depending on the member's effective date. If the monthly contribution is not received within 5 days of the due date, an administrative fee may be assessed to track, receive, and post the monthly contribution. If the monthly contribution is not received by the end of the month, a membership will become inactive as of the last day of the month in which a monthly contribution was received.

MEMBERSHIP QUALIFICATIONS

Any member who has a membership that has become inactive will be able to reapply for membership under the terms outlined to them in writing by Unity Healthshare, LLC. A member will not be able to reapply for membership if their account has been inactive a total of three times.

Needs occurring after a member's inactive date and before they reapply are not eligible for sharing.

Administrative Costs. The fees for the first two months of membership are applied as an administrative fee. Beginning the third month of membership and each month following, a fee of $25 is assigned to administrative costs from each contribution amount regardless of family size. A single, couple, or family membership all contribute $25 from their monthly contribution for administration. In addition, the annual membership dues are also utilized by Unity Healthshare, LLC to defray administrative costs.

When Available Shares are less than Eligible Needs. In any given month, the available suggested share amounts may or may not meet the eligible needs submitted for sharing. If a member's eligible bills exceed the available shares to meet those needs, the following actions may be taken:

1. A pro-rata sharing of eligible needs may be initiated, whereby the members share a percentage of eligible medical bills within that month and hold back the balance of those needs to be shared the following month.
2. If the suggested share amount is not adequate to meet the eligible needs submitted for sharing over a 60-day period, then the suggested share amount may be increased in sufficient proportion to satisfy the eligible needs. This action may be undertaken temporarily or on an ongoing basis.

Other Criteria. Children under the age of 18 may not qualify for their own membership. Non-U.S. citizens may qualify for membership as determined by Unity Healthshare, LLC on a case-by-case basis.

Monthly Contributions

Monthly contributions are voluntary contributions or gifts that are non-refundable. As a non-insurance membership, neither Unity Healthshare, LLC nor the membership are liable for any part of an individual's medical need. All contributors are responsible for their own medical needs. Although monthly contributions are voluntary contributions or gifts, there are administrative costs associated with monitoring the receipt and disbursement of such contributions or gifts. Therefore, declined credit cards, returned ACH payments, or any contribution received after the members reoccurring active date may incur an administrative fee.

Important Information About Plan Changes:

Members wishing to change to a membership type other than that which they are currently participating may, at the discretion of Unity Healthshare, LLC, be required to submit a new signed and dated membership application for review. Membership type changes can only become effective on the first of the month after the new membership application has been approved.

1. When switching from one annual product category to another (i.e. AlieraCare to Unity Healthshare's Careplus Advantage) your plan will be reset as if it is a new enrollment. This rule does not apply when transitioning from an InterimCare plan.
2. You are allowed two plan changes per membership year. The first is free of cost, the second will incur the application fee of the desired product.

Contributors wishing to discontinue participation in the membership must submit the request in writing by the 20th day of the month before which the contributions will cease. The request should contain the reason why the contributor is discontinuing participation in the membership. Should the contributor fail to follow these guidelines as they pertain to discontinuing their participation in the membership and later wish to reinstate their membership, unsubmitted contributions from the prior participation must be submitted with a new application.

A member is not eligible for cost sharing when a member:

A) Receives care within the first 60 days of the plan and cancels membership within 30 days of receiving medical care; except within the last 90 days of the membership term;

B) Receives or requires surgery within the first 60 days of becoming a member except in the case of an accident.

Early Voluntary Termination

Members of the Unity Healthshare, LLC may terminate their membership at any time, with 30 days prior notice. Unity Healthshare, LLC plans are not a substitute for "short term medical plans". Medical expenses incurred during the term of the membership and followed by early voluntary termination within 90 days of incurring medical expenses, will be reviewed and may not be eligible for cost sharing, where the early termination was not as a direct result of affordability issues with the health sharing program.

Statement of Beliefs

At the core of what we do, and how we relate to and engage with one another as a community of people, is a set of common beliefs. Our Statement of Shared Beliefs is as follows:

1. We believe that our personal rights and liberties originate from God and are bestowed on us by God.
2. We believe every individual has a fundamental religious right to worship God in his or her own way.
3. We believe it is our moral and ethical obligation to assist our fellow man when they are in need per our available resources and opportunity.
4. We believe it is our spiritual duty to God and our ethical duty to others to maintain a healthy lifestyle and avoid foods, behaviors, or habits that produce sickness or disease to ourselves or others.
5. We believe it is our fundamental right of conscience to direct our own healthcare in consultation with physicians, family, or other valued advisors.

Definitions of Terms

Terms used throughout the Member Quick Guide and other documents are defined as follows:

Affiliated Practitioner. Medical care professionals or facilities that are under contract with a network of providers with whom Unity Healthshare, LLC works. Affiliated providers are those that participate in the PHCS network. A list of providers can be found at http://www.multiplan.com.

Application Date. The date Unity Healthshare, LLC receives a complete membership application.

Combined Membership. Two or more family members residing in the same household.

Contributor. Person named as head of household under the membership.

Dependent. The head of household's spouse or unmarried child(ren), under the age of 20 – 26 if a full-time student, who are the head of household's dependent by birth, legal adoption, or marriage who is participating under the same combined membership.

Eligible. Medical needs that qualify for voluntary sharing of contributions from escrowed funds, subject to the sharing limits.

Escrow Instructions. Instructions contained on the membership application outlining the order in which voluntary monthly contributions may be shared by Unity Healthshare, LLC.

Guidelines. Provided as an outline for eligible medical needs in which contributions are shared in accordance with the membership's escrow instructions.

DEFINITION OF TERMS

Head of Household. Contributor participating by himself or by herself; or the husband or father that participates in the membership; or the wife or mother that participates in the membership. The Head of Household is the oldest member on the plan.

Licensed Medical Physician. An individual engaged in providing medical care and who has received state license approval as a practicing Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

Medically Necessary. A service, procedure, or medication necessary to restore or maintain physical function and is provided in the most cost-effective setting consistent with the member's condition. Services or care administered as a precaution against an illness or condition or for the convenience of any party are not medically necessary. The fact that a provider may prescribe, administer, or recommend services or care does not make it medically necessary, even if it is not listed as a membership limitation or an ineligible need in these guidelines. To help determine medical necessity, Unity Healthshare, LLC may request the member's medical records and may require a second opinion from an affiliated provider.

Member(s). A person(s) who qualifies to receive voluntary sharing of contributions for eligible medical needs per the membership clearing house instructions, guidelines, and membership type.

Member Shared Responsibility Amounts (MSRA). The amounts of an eligible need that do not qualify for sharing because the member is responsible for those amounts.

Membership. All members of Unity Healthshare, LLC.

Membership Eligibility Manual. The reference materials that contain the criteria used to determine if a potential member is eligible for participation in the membership and if any membership limitations apply.

Membership Type. HCSM sharing options are available with different member shared responsibility amounts (MSRA) and sharing limits as selected in writing on the membership application and approved by Unity Healthshare, LLC.

Monthly Contributions. Monetary contributions, excluding the annual membership fee, voluntarily given to Unity Healthshare, LLC. to hold as an escrow agent and to disburse according to the membership escrow instructions.

Need(s). Charges or expenses for medical services from a licensed medical practitioner or facility arising from an illness or accident for a single member.

DEFINITION OF TERMS

Non-affiliated Practitioner. Medical care professionals or facilities that are not participating within the current network.

Pre-existing Condition. Any illness or accident for which a person has been diagnosed, received medical treatment, been examined, taken medication, or had symptoms within 24 months prior to the effective date. Symptoms include but are not limited to the following: abnormal discharge or bleeding; abnormal growth/break; cut or tear; discoloration; deformity; full or partial body function loss; obvious damage, illness, or abnormality; impaired breathing; impaired motion; inflammation or swelling; itching; numbness; pain that interferes with normal use; unexplained or unplanned weight gain or loss exceeding 25% of the total body weight occurring within a six-month period; fainting, loss of consciousness, or seizure; abnormal results from a test administered by a medical practitioner.

Usual, Customary and Reasonable (UCR). The lesser of the actual charge or the charge most other providers would make for those or comparable services or supplies, as determined by Unity Healthshare, LLC.

Contributors' Instructions and Conditions

By submitting monthly contributions, the contributors instruct Unity Healthshare, LLC to share clearing house funds in accordance with the membership instructions. Since Unity Healthshare, LLC has nothing to gain or lose financially by determining if a need is eligible or not, the contributor designates Unity Healthshare, LLC as the final authority for the interpretation of these guidelines. By participation in the membership, the member accepts these conditions as enforceable.

PART III

Your Summary of Cost Sharing, Eligible Needs, & Limits

See the Appendix for other limits and conditions of sharing by plan

Eligible Medical Expenses*

Medical Expenses Eligible for Sharing. Medical costs are shared on a per person, per incident basis for illnesses or injuries incurring medical expenses after the membership effective date when medically necessary and provided by or under the direction of licensed Physicians, Osteopaths, Urgent Care facilities, clinics, emergency rooms, or hospitals (in-patient and out-patient), or other approved providers. Unless otherwise limited or excluded by these Guidelines, medical expenses eligible for sharing include, but are not limited to, physician and hospital services, emergency medical care, surgical procedures, medical testing, x-rays, ambulance transportation, and prescriptions.

1. **Allergy Office Visits and Testing**
2. **Anesthesiologist Services**
3. **Ambulance.** Emergency land or air ambulance transportation to the nearest medical facility capable of providing the medically necessary care to avoid seriously jeopardizing the sharing member's life or health. Air transportation is limited to $10,000.
4. **B12 Injections.** Eligible at a PCP or Specialist only.
5. **Birthing Center.** Eligible after MSRA.
6. **Cancer.** Cancer sharing eligibility is available immediately for new occurrences of cancer. Any pre-existing or recurring cancer condition is not eligible for sharing. Cancer sharing will not be available for individuals who have cancer at the time of or five (5) years prior to application. If cancer existed outside of the 5-year time frame of a pre-existing look-back, the following must be met in the five (5) years prior to application, to be eligible for future, non-recurring cancer incidents. 1. The condition had not been treated nor was future treatment prescribed/planned; 2. The condition had not produced harmful symptoms (only benign symptoms); 3. The condition had not deteriorated. Cancer is limited to a maximum per term of $500,000 when applicable.
7. **Chemotherapy.** Subject to cancer limitations.
8. **Radiation Therapy.** Subject to cancer limitations.
9. **Chronic Maintenance.** Chronic maintenance is eligible when a member has chosen a plan with chronic maintenance specifically included and a listing of the maximum number of allowable visits. See 'Appendix A' attached hereto.

YOUR SUMMARY OF COST SHARING, ELIGIBLE NEEDS, & LIMITS

10. **Cardiac Rehabilitation.** Eligible after MSRA.
11. **Diagnostic Lab & Pathology**. Eligible after MSRA.
12. **Diagnostic Lab & Radiology.** Eligible after MSRA.
13. **Emergency Room.** Emergency room services for stabilization or initiation of treatment of a medical emergency condition provided on an outpatient basis at a hospital, clinic, or Urgent Care facility, including when hospital admission occurs within twenty-three (23) hours of emergency room treatment.
14. **Eye Care**. Limited to medical necessity and accident only. Excludes cosmetic, frames, lenses, contacts, extensive eye exams and subject to pre-existing limitations.
15. **Home Health Care**. Eligible after MSRA.
16. **Home Infusion Services.** Eligible after MSRA.
17. **Hospice Services.** Eligible after MSRA.
18. **Hospitalization.** Hospital charges for inpatient or outpatient hospital treatment or surgery for a medically diagnosed condition.
19. **Maternity.** AlieraCare Bronze, Silver, and Gold plans have full maternity benefits. Medical expenses for maternity ending in a delivery by emergency cesarean section that are medically necessary, are eligible for sharing up to $8,000, subject to the applicable Member Shared Responsibility Amount. Medical expenses for a newborn arising from complications at the time of delivery, including, but not limited to, premature birth, are treated as a separate incident and limited to $50,000 of eligible sharing, subject to the Member Shared Responsibility Amount.
20. **Mental Health.** Plan holders are eligible for $2,500 (max) for Psychotherapy office visits and $1,000 (max) at out-patient facilities. Excludes in-patient and residential settings.
21. **Occupational Therapy.** Up to six (6) visits per membership year for occupational therapy
22. **Organ Transplant Limit.** Eligible needs requiring organ transplant may be shared up to a maximum of $150,000 per member. This includes all costs in conjunction with the actual transplant procedure. Needs requiring multiple organ transplants will be considered on a case-by-case basis.
23. **Physical Therapy.** Up to six (6) visits per membership year for physical therapy by a licensed physical therapist.
24. **Podiatry Services.** Eligible after MSRA.
25. **Preadmission Testing.** Eligible after MSRA.

YOUR SUMMARY OF COST SHARING, ELIGIBLE NEEDS, & LIMITS

26. **Prescription Drugs.** The AlieraCare plan includes a service by RX Valet, which includes discounts for prescription drugs. See Appendix for details.
27. **Preventive.** Most programs from either Unity or Aliera provide everyone with the necessities of the 63 preventive care services as outlined by the United States Preventive Task force. (Excludes CarePlus Advantage.) Preventive care includes the PCP office visit and does not require a co-expense or consult fee.
28. **Primary Care.** Depending on your plan choice, primary care is at the core of preventing medical issues from escalating into a more catastrophic need. See Appendix for the specific plan details.
29. **Pulmonary Rehab**
30. **Retail Walk in Clinics.** Subject to specialty consult fee based on plan chosen. See Appendix for details.
31. **Routine Hearing Exams.** At Primary Care (PCP) only.
32. **Routine Nursing Care of Newborn Infant.** Eligible after MSRA.
33. **Skilled Nursing Facility.** Eligible after MSRA.
34. **Sleep Disorders**. Overnight Sleep Testing Limit: All components of a polysomnogram must be completed in one session. A second overnight test will not be eligible for sharing under any circumstance. Overnight sleep testing must be medically necessary and will require pre-authorization. Allowed charges will not exceed the Usual, Customary, and Reasonable charges for the area.
35. **Smoking Cessation.** Members who have acknowledged they smoke and made an additional contribution are provided the opportunity to obtain free smoking cessation medication and counseling through the eligible preventive services.
36. **Specialty Care.** For most everyday medical conditions, your PCP is your one-stop medical shop. However, there are cases when it's time to see a specialist who's had additional education and been board certified for that specialty. For situations like these, the AlieraCare Bronze, Silver, and Gold plans provides specialty care benefits at the cost of just a consult fee. A member will need to receive a PCP referral to see a specialist for treatment or consultation outside of their scope of knowledge.
37. **Speech Therapy.** Up to six (6) visits per membership year. Only applicable after a stroke.
38. **Surgical Benefits.** Non-life-threatening surgical benefits are not available for the first 60 days of membership. Please verify eligibility by calling Member Services before receiving any surgical services.

YOUR SUMMARY OF COST SHARING, ELIGIBLE NEEDS, & LIMITS

39. **Telemedicine.** Telemedicine is included in all AlieraCare programs offered by Unity Healthshare, LLC and Aliera Healthcare as your first line of defense. Your membership provides you and your family 24/7/365 access to a U.S. Board certified medical doctor.
40. **Urgent Care.** If your plan provides cost sharing for Urgent Care, you will have the added benefit of enjoying the ability to choose an Urgent Care facility in lieu of an emergency room. See the Appendix for any urgent care options and any limitations to plan.
41. **X-rays.** X-rays listed on your plan details in the Appendix are for imaging services at PCP or Urgent Care facilities only and require a $25 read fee per view at time of service. Your MSRA will apply to all other x-rays. MRI, CT Scans and other diagnostics must be paid with your MSRA before cost sharing is provided.

**Medical Expense Incident is any medically diagnosed condition receiving medical treatment and incurring medical expenses of the same diagnosis. All related medical bills of the same diagnosis comprise the same incident. Such expenses must be submitted for sharing in the manner and form specified by Unity Healthshare, LLC. This may include, but not be limited to, standard industry billing forms (HCFA1500 and/or UB 92) and medical records. Members share these kinds of costs.*

LIMITS OF SHARING

Total eligible needs shared from member contributions are limited as defined in this section and as further limited in writing to the individual member.

1. Lifetime Limits. $1,000,000: the maximum amount shared for eligible needs over the course of an individual member's lifetime.
2. Per Incident. The occurrence of one particular sickness, illness, or accident.
3. Cancer Limits when applicable. Cancer is limited to a maximum per term of $500,000 when applicable
4. Member Shared Responsibility Amounts (MSRA). Eligible needs are limited to the amounts in excess of the MSRA, which are applied per individual member per the plan year. MSRA(s). The eligible amount that does not qualify for sharing based on the membership type chosen by the member.
5. Non-Affiliated Practitioner. Services rendered by a non-affiliated practitioner will not be eligible for sharing nor will any amount be applied to your MRSA unless specified differently in the plan details contained herein.

Cost Sharing for Pre-Existing Conditions

Bronze Program cost sharing parameters for pre-existing conditions. The following restrictions are only applicable to a pre-existing condition and do not affect normal sharing for other non-pre-existing related incidents, events, etc.

1. Chronic or recurrent conditions that have evidenced signs/symptoms and/or received treatment and/or medication within the past 24 months are not eligible for sharing during the first 24 months of membership.
2. Upon inception of the 25th month of continuous membership and thereafter, the condition may no longer be subject to the pre-existing condition sharing limitations.
3. Appeals may be considered for earlier sharing in surgical interventions when it is in the mutual best interest of both the members and the membership to do so.

Silver Program cost sharing parameters for pre-existing conditions. The following restrictions are only applicable to a pre-existing condition and do not affect normal sharing for other non-pre-existing related incidents, events, etc.

1. During the first two years of continuous membership, sharing is available up to $10,000 of total medical expenses incurred for pre-existing conditions per year, after a separate MSRA equal to two times your plan MSRA.

LIMITS OF SHARING

2. Upon inception of the 25th month of continuous membership and thereafter, the condition may no longer be subject to the pre-existing condition sharing limitations.
3. Appeals may be considered for earlier sharing in surgical interventions when it is in the mutual best interest of both the members and the membership to do so.

Gold Program cost sharing parameters for pre-existing conditions. The following restrictions are only applicable to a pre-existing condition and do not affect normal sharing for other non-pre-existing related incidents, events, etc.

1. During the first two years of continuous membership, sharing is available up to $20,000 of total medical expenses incurred for a pre-existing condition per year, after a separate MSRA equal to two times your plan MSRA.
2. Upon the inception of the 25th month of continuous membership and thereafter, the condition may no longer be subject to the pre-existing condition sharing limitations.
3. Appeals may be considered for earlier sharing in surgical interventions when it is in the mutual best interest of both the members and the membership to do so.

Other Resources. Benefits available to the member from other sources such as insurance, VA, Tricare, private grants, or by a liable third party (primary, auto, home insurance, educational, etc.), will be considered the member's primary benefit source, and the member will be required to file medical claims with those providers first. If there are medical expenses that those sources do not pay, the member is authorized to submit the excess medical expenses for sharing, and the MSRA will be waived, up to the maximum MSRA as defined in the member's plan. The MSRA will only be waived if a third party source pays on the member's behalf. Sharing of monthly contributions for a need that is later paid, or found to payable by another source will automatically allow Unity Healthshare, LLC full rights to recover the amounts that were shared with the member.

MEDICAL EXPENSES NOT GENERALLY SHARED BY HCSM

Only needs incurred on or after the membership effective date are eligible for sharing under the membership instructions. The member (or the member's provider) must submit a request for sharing in the manner and format specified by Unity Healthshare, LLC. This includes, but is not limited to, a Need Processing Form, standard industry billing forms (HCFA 1500 and/or most recent UB form), and may include medical records. All participating members have a responsibility to abide by the Members' Rights and Responsibilities published by Unity Healthshare, LLC and are included at the end of these guidelines. Needs arising from any one of the following are not eligible for sharing under the membership clearing house instructions:

1. Abortion Services
2. Acupuncture Services
3. Aqua Therapy
4. Biofeedback
5. Birth Control (Male) Elective Sterilization
6. Birth Control (Male) Reversal of Sterilization
7. Cataract Contacts or Glasses
8. Chemical Face Peels
9. Chiropractic Services
10. Christian Science Practitioner
11. Cochlear Devices
12. Cosmetic Surgery
13. Custodial Care Services
14. Dental Services
15. Dermabrasion Services
16. Diabetic Insulin, Supplies, and Syringes
17. Doula
18. Durable Medical Equipment
19. Education Services
20. Exercise Equipment
21. Experimental Drugs
22. Experimental Procedures
23. Extreme sports: Sports that voluntarily put an individual in a life-threatening situation. Sports such as but not limited to "free climb" rock climbing, parachuting, fighting, martial arts, racing, cliff diving, powerboat racing, air racing, motorcycle racing, extreme skiing, wingsuit, and similar.
24. Gender Dysphoria Office Visit – PCP
25. Gender Dysphoria Office Visit – Specialist
26. Gender Dysphoria
27. Genetic Testing

MEDICAL EXPENSES NOT GENERALLY SHARED BY HCSM

28. Group Therapy Services
29. Hemodialysis
30. Hypnotherapy Services
31. Infertility Diagnostic or treatment
32. Infertility Services
33. Investigational Drugs/Procedures
34. Lifestyles or activities engaged in after the application date that conflicts with the Statement of Beliefs (on the membership application).
35. Massage Therapy
36. Midwifery
37. MILIEU Situational Therapy Services
38. Morbid Obesity
39. Non- Routine Hearing Exams & Hearing Aids
40. Nurse Practitioner
41. Orthotics (back, neck, knee, wrist, etc.)
42. Orthopedic Shoes
43. Pain Management
44. Personal aircraft includes hang gliders, parasails, ultra-lights, hot air balloons, sky/diving, and any other aircraft not operated by a commercially licensed public carrier.
45. Personal Convenience Items
46. Post-Surgical Bras
47. Private Duty Nursing Services
48. Professional Sports Injuries
49. Prosthetic Appliances
50. Robotic Surgery
51. Self-Inflicted Injury
52. Sexual Dysfunction Services
53. Sexual Transformation Services
54. Substance Abuse
55. Surgical Stockings
56. Treatment or referrals received or obtained from any family member including, but not limited to, father, mother, aunt, uncle, grandparent, sibling, cousin, dependent, or any in-laws.

PRE-AUTHORIZATION REQUIRED

Non-Emergency Surgery, Procedure, or Test. The member must have the following procedures or services pre-authorized as medically necessary prior to receiving the service. Failure to comply with this requirement will render the service not eligible for sharing.

Hospitalizations. Non-emergency prior to admission; emergency visits notification to Unity Healthshare, LLC within 48 hours.

- MRI studies/CT scans/Ultrasounds
- Sleep studies must be completed in one session
- Physical or occupational therapy
- Speech therapy under limited circumstances only
- Cardiac testing, procedures, and treatments
- In-patient cancer testing, procedures, and treatments
- Infusion therapy within facility
- Nuclide studies
- EMG/EEG
- Ophthalmic procedures
- ER visits, emergency surgery, procedure, or test: Non-emergency use of the emergency room is not eligible for sharing. Unity Healthshare, LLC must be notified of all ER visits within 48 hours. Medical records will be reviewed for all ER visits to determine eligibility. An emergency is defined as treatment that must be rendered to the patient immediately for the alleviation of the sudden onset of an unforeseen illness or injury that, if not treated, would lead to further disability or death. Examples of an emergency include, but are not limited to, severe pain, choking, major bleeding, heart attack, or a sudden, unexplained loss of consciousness.

Eligibility for Cancer Needs. In order for needs related to cancer hospitalization of any type to be eligible (e.g. breast, colorectal, leukemia, lymphoma, prostate, skin, etc.), the member must meet the following requirements:

The member is required to contact Unity Healthshare, LLC within 30 days of diagnosis. If the member fails to notify Unity Healthshare, LLC within the 30-day time frame, the member will be responsible for 50% of the total allowed charges after the MRSA(s) has been assessed to the member for in-patient cancer hospitalization.

Early detection provides the best chance for successful treatment and in the most cost effective manner. Effective January 1, 2017, the membership requires that all members aged 40 and older receive appropriate screening tests every other year – mammogram or thermography and pap smear with pelvic exams for women and PSA testing for men. Failure to obtain biannual mammograms and gynecological tests listed above for women or PSA tests for men will render future needs for breast, cervical, endometrial, ovarian, or prostate cancer ineligible for sharing.

DISPUTE RESOLUTION AND APPEAL

Unity Healthshare, LLC is a voluntary association of like-minded people who come together to assist each other by sharing medical expenses. Such a sharing and caring association does not lend itself well to the mentality of legally enforceable rights. However, it is recognized that differences of opinion will occur, and that a methodology for resolving disputes must be available. Therefore, by becoming a Sharing Member of Unity Healthshare, LLC, you agree that any dispute you have with or against Unity Healthshare, LLC, its associates, or employees will be settled using the following steps of action, and only as a course of last resort.

If a determination is made with which the sharing member disagrees and believes there is a logically defensible reason why the initial determination is wrong, then the sharing member may file an appeal.

A. 1st Level Appeal. Most differences of opinion can be resolved simply by calling Unity Healthshare, LLC who will try to resolve the matter telephonically within a reasonable amount of time.

B. 2nd Level Appeal. If the sharing member is unsatisfied with the determination of the member services representative, then the sharing member may request a review by the Internal Resolution Committee, made up of three Unity Healthshare, LLC officials. The appeal must be in writing, stating the elements of the dispute and the relevant facts. Importantly, the appeal should address all of the following:

1. What information does Unity Healthshare, LLC have that is either incomplete or incorrect?
2. How do you believe Unity Healthshare, LLC has misinterpreted the information already on hand?
3. Which provision in the Unity Healthshare, LLC Guidelines do you believe Unity Healthshare, LLC applied incorrectly?

Within thirty (30) days, the Internal Resolution Committee will render a written decision, unless additional medical documentation is required to make an accurate decision.

C. 3rd Level Appeal. Should the matter remain unresolved, then the aggrieved party may ask that the dispute be submitted to three sharing members in good standing and randomly chosen by Unity Healthshare, LLC, who shall agree to review the matter and shall constitute an External Resolution Committee. Within thirty (30) days the External Resolution Committee shall render their opinion in writing, unless additional medical documentation is required to make an accurate decision.

DISPUTE RESOLUTION AND APPEAL

D. **Final Appeal.** If the aggrieved sharing member disagrees with the conclusion of his/her fellow sharing members, then the aggrieved party may ask that the dispute be submitted to a medical expense auditor, who shall have the matter reviewed by a panel consisting of personnel who were not involved in the original determination and who shall render their opinion in writing within thirty (30) days, unless additional medical documentation is required to make an accurate decision.

E. **Mediation and Arbitration.** If the aggrieved sharing member disagrees with the conclusion of the Final Appeal Panel, then the matter shall be resolved by first submitting the disputed matter to mediation. If the dispute is not resolved the matter will be submitted to legally binding arbitration in accordance with the Rules and Procedure of the American Arbitration Association. Sharing members agree and understand that these methods shall be the sole remedy to resolve any controversy or claim arising out of the Sharing Guidelines, and expressly waive their right to file a lawsuit in any civil court against one another for such disputes; except to enforce an arbitration decision. Any arbitration shall be held in Atlanta, Georgia, and conducted in the English language subject to the laws of the State of Georgia. Unity Healthshare, LLC shall pay the filing fees for the arbitration and arbitrator in full at the time of filing. All other expenses of the arbitration shall be paid by each party including costs related to transportation, accommodations, experts, evidence gathering, and legal counsel. Further agreed that the aggrieved sharing member shall reimburse the full costs associated with the arbitration, should the arbitrator render a judgment in favor of Unity Healthshare, LLC and not the aggrieved sharing member.

The aggrieved sharing member agrees to be legally bound by the arbitrator's final decision. The parties may alternatively elect to use other professional arbitration services available in the Atlanta metropolitan area, by mutual agreement.

APPENDIX A: PLAN DETAILS BRONZE LEVEL

PPO Network	PPO Multiplan PHCS	
Eligible Medical Cost Sharing	**Network**	**Non-Network**
Eligible prior to meeting Member Shared Responsibility Amount (MSRA)		
Wellness & Preventive Care	100%	50% after MSRA
Telemedicine	Unlimited	Unlimited
Primary Care	$50 Consult Fee	50% after MSRA
Specialty Care	$125 Consult Fee	50% after MSRA
Urgent Care	$100 Consult Fee	50% after MSRA
Emergency Room Services[1] Emergency room services including hospital facility and physician charges.	$500 Consult Fee	$500 Consult Fee
Eligible after meeting Member Shared Responsibility Amount (MSRA)[2,3,4]		
MSRA Per member 1 (1–2 members)	$1,000, $2,500, $5,000, $10,000	50% towards MSRA
MSRA Family maximum (3+ members)	$3,000, $7,500, $15,000, $30,000	50% towards MSRA
Out-of-Pocket Maximum Per member 1 (1–2 members)	$3,000, $7,500, $15,000, $30,000	$6,000, $15,000, $30,000, $60,000
Out-of-Pocket Maximum – Family maximum (3+ members)	$9,000, $22,500, $45,000, $90,000	$18,000, $45,000, $90,000, $180,000
Co-expense (Plan Pays)	60% after MSRA	50% after MSRA
Hospitalization In-Patient]	60% after MSRA	50% after MSRA
Hospitalization Out-Patient	60% after MSRA	50% after MSRA
Imaging Eligible charges for CT, PET scans, MRIs, and the charges for related supplies. [Unity]	60% after MSRA	50% after MSRA
Laboratory Out-Patient and Professional Services Sharing eligible for professional components of labs, including office, out-patient, and in-patient charges.	60% after MSRA	50% after MSRA
X-rays and Diagnostic Imaging Sharing eligible for the professional components of labs, including the office, out-patient, and in-patient charges.	60% after MSRA	50% after MSRA
Generic Prescription Drugs	No cost-sharing	Not eligible
Preferred Brand Drugs	50% cost-sharing*	Not eligible
Non-Preferred Brand Drugs	No cost-sharing	Not eligible
Mail-Order	75% cost-sharing*	Not eligible

See Legal Appendix on page 37

APPENDIX A: PLAN DETAILS SILVER LEVEL

PPO Network	PPO Multiplan PHCS	
Eligible Medical Cost Sharing	**Network**	**Non-Network**
Eligible prior to meeting Member Shared Responsibility Amount (MSRA)		
Wellness & Preventive Care	100%	60% after MSRA
Telemedicine	Unlimited	Unlimited
Primary Care	$35 Consult Fee	60% after MSRA
Specialty Care	$75 Consult Fee	60% after MSRA
Urgent Care	$75 Consult Fee	60% after MSRA
Emergency Room Services [Aliera] Emergency room services including hospital facility and physician charges.	$300 Consult Fee	$500 Consult Fee
Eligible after meeting Member Shared Responsibility Amount (MSRA)[2,3,4]		
MSRA Per member 1 (1–2 members)	$1,000, $2,500, $5,000, $10,000	60% towards MSRA
MSRA Family maximum (3+ members)	$3,000, $7,500, $15,000, $30,000	60% towards MSRA
Out-of-Pocket Maximum Per member 1 (1–2 members)	$3,000, $7,500, $15,000, $30,000	$6,000, $15,000, $30,000, $60,000
Out-of-Pocket Maximum – Family maximum (3+ members)	$9,000, $22,500, $45,000, $90,000	$18,000, $45,000, $90,000, $180,000
Co-expense (Plan Pays)	70% after MSRA	60% after MSRA
Hospitalization In-Patient	70% after MSRA	60% after MSRA
Hospitalization Out-Patient [Unity]	70% after MSRA	60% after MSRA
Imaging Eligible charges for CT, PET scans, MRIs, and the charges for related supplies.	70% after MSRA	60% after MSRA
Laboratory Out-Patient and Professional Services Sharing eligible for professional components of labs, including office, out-patient, and in-patient charges.	70% after MSRA	60% after MSRA
X-rays and Diagnostic Imaging Sharing eligible for the professional components of labs, including the office, out-patient, and in-patient charges.	70% after MSRA	60% after MSRA
Generic Prescription Drugs	No cost-sharing	Not eligible
Preferred Brand Drugs	50% cost-sharing*	Not eligible
Non-Preferred Brand Drugs	No cost-sharing	Not eligible
Mail-Order	75% cost-sharing*	Not eligible

See Legal Appendix on page 37

APPENDIX A: PLAN DETAILS GOLD LEVEL

PPO Network	PPO Multiplan PHCS	
Eligible Medical Cost Sharing	**Network**	**Non-Network**
Eligible prior to meeting Member Shared Responsibility Amount (MSRA)		
Wellness & Preventive Care	100%	70% after MSRA
Telemedicine	Unlimited	Unlimited
Primary Care	$20 Consult Fee	70% after MSRA
Specialty Care	$75 Consult Fee	70% after MSRA
Urgent Care	$75 Consult Fee	70% after MSRA
Emergency Room Services Emergency room services including hospital facility and physician charges.	$150 Consult Fee	$300 Consult Fee
Eligible after meeting Member Shared Responsibility Amount (MSRA)[2,3,4]		
MSRA Per member 1 (1–2 members)	$1,000, $2,500, $5,000, $10,000	70% towards MSRA
MSRA Family maximum (3+ members)	$3,000, $7,500, $15,000, $30,000	70% towards MSRA
Out-of-Pocket Maximum Per member 1 (1–2 members)	$3,000, $7,500, $15,000, $30,000	$6,000, $15,000, $30,000, $60,000
Out-of-Pocket Maximum – Family maximum (3+ members)	$9,000, $22,500, $45,000, $90,000	$18,000, $45,000, $90,000, $180,000
Co-expense (Plan Pays)	80% after MSRA	70% after MSRA
Hospitalization In-Patient	80% after MSRA	70% after MSRA
Hospitalization Out-Patient	80% after MSRA	70% after MSRA
Imaging Eligible charges for CT, PET scans, MRIs, and the charges for related supplies.	80% after MSRA	70% after MSRA
Laboratory Out-Patient and Professional Services Sharing eligible for professional components of labs, including office, out-patient, and in-patient charges.	80% after MSRA	70% after MSRA
X-rays and Diagnostic Imaging Sharing eligible for the professional components of labs, including the office, out-patient, and in-patient charges.	80% after MSRA	70% after MSRA
Generic Prescription Drugs	No cost-sharing	Not eligible
Preferred Brand Drugs	50% cost-sharing*	Not eligible
Non-Preferred Brand Drugs	No cost-sharing	Not eligible
Mail-Order	75% cost-sharing*	Not eligible

See Legal Appendix on page 37

APPENDIX A: PLAN DETAILS BRONZE

Lifetime Maximum Sharing: $1,000,000

Bronze Program cost-sharing parameters for pre-existing conditions. Hospitalization, In-Patient and Out-Patient Surgery, Specialty Care, and Emergency Room services for pre-existing conditions have a 24 month waiting period. All other healthcare services for pre-existing conditions are eligible upon effective date.

a. Pre-existing Condition: chronic or recurrent conditions that have evidenced signs/symptoms and/or received treatment and/or medication within the past 24 months are not eligible for sharing during the first 24 months of membership.

b. Upon the 25th month of continuous membership and thereafter, the condition will no longer be subject to the pre-existing condition sharing limitations.

c. Appeals may be considered for earlier sharing in surgical interventions when it is in the best interest of both the members and the membership to do so.

Cancer sharing is available immediately. Cancer sharing is only available for non-recurrent cancer diagnosis.

1. ER visits are subject to review, and are meant only for life threatening situations.
2. All members seeking cost-sharing must use the prescription services Rx Valet included with your plan. Prescription drugs are eligible for cost-sharing by the percentage shown once a separate MSRA of $1,500 for all prescriptions is met. Members are required to pay prescription cost out-of-pocket before submitting receipts to Unity Healthshare, LLC mailing address, Attn. Unity Rx Claims, for review and cost-sharing. Maximum reimbursement of $4,000 per plan year.
3. Members under the age of 20 can qualify as dependents. Members ages 20–26 can qualify as a dependent if proven to be a full-time student. Unity Healthshare, LLC plans follow medical eligibility review protocols described in the plan but are not a promise to pay. Sharing is available for all eligible medical needs.

Administrative and Conditional Fees: $125 one-time application fee per enrollment

Products NOT available in: AK, HI, MD, ME, PR, WA, WY; subject to change w/o prior notice.

APPENDIX A: PLAN DETAILS SILVER

Lifetime Maximum Sharing: $1,000,000

Silver Program cost-sharing parameters for pre-existing conditions. Hospitalization, In-Patient and Out-Patient Surgery, Specialty Care, and Emergency Room services for pre-existing conditions have limitations during the first 24 months of membership.

a. During the first two years (24 months) of continuous membership, sharing is available up to $10,000 of total medical expenses incurred for pre-existing conditions per year, after a separate MSRA equal to two times your plan MSRA.

b. Upon inception of the 25th month of continuous membership and thereafter, the condition may no longer be subject to the pre-existing condition sharing limitations.

c. Appeals may be considered for earlier sharing in surgical interventions when it is in the mutual best interest of both the members and the membership to do so.

Cancer sharing is available immediately. Cancer sharing is only available for non-recurrent cancer diagnosis.

1. ER visits are subject to review, and are meant only for life threatening situations.
2. All members seeking cost-sharing must use the prescription services Rx Valet included with your plan. Prescription drugs are eligible for cost-sharing by the percentage shown once a separate MSRA of $1,500 for all prescriptions is met. Members are required to pay prescription cost out-of-pocket before submitting receipts to Unity Healthshare, LLC mailing address, Attn. Unity Rx Claims, for review and cost-sharing. Maximum reimbursement of $4,000 per plan year.
3. Members under the age of 20 can qualify as dependents. Members ages 20–26 can qualify as a dependent if proven to be a full-time student. Unity Healthshare, LLC plans follow medical eligibility review protocols described in the plan but are not a promise to pay. Sharing is available for all eligible medical nee

Administrative and Conditional Fees: $125 one-time application fee per enrollment

Products NOT available in: AK, HI, MD, ME, PR, WA, WY; subject to change w/o prior notice.

APPENDIX A: PLAN DETAILS GOLD

Lifetime Maximum Sharing: $1,000,000

Gold Program cost-sharing parameters for pre-existing conditions. Hospitalization, Hospitalization, In-Patient and Out-Patient Surgery, Specialty Care, and Emergency Room services for pre-existing conditions have limitations during the first 24 months of membership.

a. During the first two years (24 months) of continuous membership, sharing is available up to $20,000 of total medical expenses incurred for pre-existing conditions per year, after a separate MSRA equal to two times your plan MSRA.

b. Upon inception of the 25th month of continuous membership and thereafter, the condition may no longer be subject to the pre-existing condition sharing limitations.

c. Appeals may be considered for earlier sharing in surgical interventions when it is in the mutual best interest of both the members and the membership to do so.

Cancer sharing is available immediately. Cancer sharing is only available for non-recurrent cancer diagnosis.

1. ER visits are subject to review, and are meant only for life threatening situations.
2. All members seeking cost-sharing must use the prescription services Rx Valet included with your plan. Prescription drugs are eligible for cost-sharing by the percentage shown once a separate MSRA of $1,500 for all prescriptions is met. Members are required to pay prescription cost out-of-pocket before submitting receipts to Unity Healthshare, LLC mailing address, Attn. Unity Rx Claims, for review and cost-sharing. Maximum reimbursement of $4,000 per plan year.
3. Members under the age of 20 can qualify as dependents. Members ages 20–26 can qualify as a dependent if proven to be a full-time student.Unity Healthshare, LLC plans follow medical eligibility review protocols described in the plan but are not a promise to pay. Sharing is available for all eligible medical needs.

Administrative and Conditional Fees: $125 one-time application fee per enrollment

Products NOT available in: AK, HI, MD, ME, PR, WA, WY; subject to change w/o prior notice.

APPENDIX B: TERMS, CONDITIONS, & SPECIAL CONSIDERATIONS

1. The Welcome Kit you received electronically includes this Quick Guide, your Membership Card(s), a Welcome Letter, and important information to activate your membership.
2. Keep your Membership Card with you at all times to present to a provider to confirm eligibility.
3. The ACA is subject to change at any time; Aliera reserves the right to adhere to those changes without notice to the Member.
4. Activate your Plan Membership by following the instructions in this Quick Guide.
5. Set up your telemedicine account by following the instructions on the Welcome Letter. Within three weeks of enrollment in Aliera's telemedicine partnering company, Members receive ID Card(s) for the telemedicine service along with instructions on how to utilize the service.
6. Telemedicine operates subject to state regulations and may not be available in certain states.
7. Telemedicine phone consultations are available 24/7/365, with face-to-face internet consultations available between the hours of 7 a.m. and 9 p.m., Monday – Friday.
8. Telemedicine does not guarantee that a prescription will be written.
9. Telemedicine does not prescribe DEA-controlled substances, non-therapeutic drugs, and certain other drugs which may be harmful because of their potential for abuse. Telemedicine doctors reserve the right to deny care for potential misuse of services.
10. Durable Medical Equipment (DME) – i.e. crutches, etc. – is not included in your Plan. Members will be charged for DME at time of service.
11. Aliera cannot guarantee that a provider will accept an Aliera Plan if the Member fails to contact the Aliera Concierge Service first.
12. Member Care Specialists are available to assist you, Monday through Friday, 8 a.m. to 8 p.m. EST at (844) 834-3456. If you call after hours, follow the prompts.
13. Plans may vary from state to state. Providers may be added or removed from Aliera's network at any time without notice.
14. Not all geographical areas are serviced by Aliera Healthcare. Should a Member visit an emergency room because urgent care facilities are unavailable in the Member's area, Aliera offers a one-time, once-a-year, $105 credit (ex gratia) to the Member to help offset the costs incurred.

APPENDIX B: TERMS, CONDITIONS, & SPECIAL CONSIDERATIONS

15. Aliera telemedicine partners do not replace the Primary Care Provider.
16. Primary Care is defined as “episodic primary care” or “sick care.” Members are responsible for paying a consult fee at the time of service; no consult fee is due for preventive service.
17. Most network facilities are able to accommodate both urgent care and primary care needs.
18. Not all PPO providers accept an AlieraCare plan. While Aliera offers one of the largest PPO networks in the country, some providers may not participate.

Disclosures

1. Aliera Healthcare, the Aliera Healthcare logo, and other plan or service logos are trademarks of Aliera Healthcare, Inc. and may not be used without written permission.
2. Aliera and Unity programs are NOT insurance. Aliera Healthcare, Inc./Unity Healthshare, LLC does not guarantee the quality of services or products offered by individual providers. Members may change providers upon 30 days’ notice if not satisfied with the medical services provided.
3. Aliera’s Healthcare Plans offer services only to Members and dependents on your Plan.
4. Aliera reserves the right to interpret the terms of this membership to determine the level of medical services received hereunder.
5. This membership is issued in consideration of the Member’s application and the Member’s payment of a monthly fee as provided under these Plans. Omissions and misstatements, or incorrect, incomplete, fraudulent, or intentional misrepresentation to the assumed risk in your application may void your membership, and services may be denied.

Abbreviations

ACA	Affordable Care Act (Obamacare)
CMS	Center for Medicare and Medicaid Services
DEA	Drug Enforcement Administration
DME	Durable Medical Equipment
DPCMH	Direct Primary Care Medical Home Plans
HCSM	Health Care Sharing Ministry
MEC	Minimum Essential Coverage
PCP	Primary Care Provider
PPO	Participating Provider Organization
UC	Urgent Care

APPENDIX C: LEGAL NOTICES

The following legal notices are the result of discussions by Unity Healthshare, LLC or other healthcare sharing ministries with several state regulators and are part of an effort to ensure that Sharing Members understand that Unity Healthshare, LLC is not an insurance company and that it does not guarantee payment of medical costs. Our role is to enable self-pay patients to help fellow Americans through voluntary financial gifts.

General Legal Notice

This program is not an insurance company nor is it offered through an insurance company. This program does not guarantee or promise that your medical bills will be paid or assigned to others for payment. Whether anyone chooses to pay your medical bills will be totally voluntary. As such, this program should never be considered as a substitute for an insurance policy. Whether you receive any payments for medical expenses and whether or not this program continues to operate, you are always liable for any unpaid bills.

State Specific Notices

Alabama Code Title 22-6A-2

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Arizona Statute 20-122

Notice: the organization facilitating the sharing of medical expenses is not an insurance company and the ministry’s guidelines and plan of operation are not an insurance policy. Whether anyone chooses to assist you with your medical bills will be completely voluntary because participants are not compelled by law to contribute toward your medical bills. Therefore, participation in the ministry or a subscription to any of its documents should not be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this ministry continues to operate, you are always personally responsible for the payment of your own medical bills.

APPENDIX C: LEGAL NOTICES

Arkansas Code 23-60-104.2

Notice: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor plan of operation is an insurance policy. If anyone chooses to assist you with your medical bills, it will be totally voluntary because participants are not compelled by law to contribute toward your medical bills. Participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive a payment for medical expenses or if this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Florida Statute 624.1265

Unity Healthshare, LLC is not an insurance company, and membership is not offered through an insurance company. Unity Healthshare, LLC is not subject to the regulatory requirements or consumer protections of the Florida Insurance Code.

Georgia Statute 33-1-20

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Idaho Statute 41-121

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

APPENDIX C: LEGAL NOTICES

Illinois Statute 215-5/4-Class 1-b

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation constitute or create an insurance policy. Any assistance you receive with your medical bills will be totally voluntary. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Whether or not you receive any payments for medical expenses and whether or not this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Indiana Code 27-1-2.1

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor its plan of operation is an insurance policy. Any assistance you receive with your medical bills will be totally voluntary. Neither the organization nor any other participant can be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Whether or not you receive any payments for medical expenses and whether or not this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Kentucky Revised Statute 304.1-120 (7)

Notice: Under Kentucky law, the religious organization facilitating the sharing of medical expenses is not an insurance company, and its guidelines, plan of operation, or any other document of the religious organization do not constitute or create an insurance policy. Participation in the religious organization or a subscription to any of its documents shall not be considered insurance. Any assistance you receive with your medical bills will be totally voluntary. Neither the organization nor any participant shall be compelled by law to contribute toward your medical bills. Whether or not you receive any payments for medical expenses, and whether or not this organization continues to operate, you shall be personally responsible for the payment of your medical bills.

Louisiana Revised Statute Title 22-318,319

Notice: The ministry facilitating the sharing of medical expenses is not an insurance company. Neither the guidelines nor the plan of operation of the ministry constitutes an insurance policy. Financial assistance for the payment of medical expenses is strictly voluntary. Participation in the ministry or a subscription to any publication issued by the ministry shall not be considered as enrollment in any health insurance plan or as a waiver of your responsibility to pay your medical expenses.

APPENDIX C: LEGAL NOTICES

Maine Revised Statute Title 24-A, §704, sub-§3

Notice: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. Participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Maryland Article 48, Section 1-202(4)

Notice: This publication is not issued by an insurance company nor is it offered through an insurance company. It does not guarantee or promise that your medical bills will be published or assigned to others for payment. No other subscriber will be compelled to contribute toward the cost of your medical bills. Therefore, this publication should never be considered a substitute for an insurance policy. This activity is not regulated by the State Insurance Administration, and your liabilities are not covered by the Life and Health Guaranty Fund. Whether or not you receive any payments for medical expenses and whether or not this entity continues to operate, you are always liable for any unpaid bills.

Mississippi Title 83-77-1

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment of medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Missouri Section 376.1750

Notice: This publication is not an insurance company nor is it offered through an insurance company. Whether anyone chooses to assist you with your medical bills will be totally voluntary, as no other subscriber or member will be compelled to contribute toward your medical bills. As such, this publication should never be considered to be insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always personally responsible for the payment of your own medical bills.

APPENDIX C: LEGAL NOTICES

Nebraska Revised Statute Chapter 44-311

IMPORTANT NOTICE. This organization is not an insurance company, and its product should never be considered insurance. If you join this organization instead of purchasing health insurance, you will be considered uninsured. By the terms of this agreement, whether anyone chooses to assist you with your medical bills as a participant of this organization will be totally voluntary, and neither the organization nor any participant can be compelled by law to contribute toward your medical bills. Regardless of whether you receive payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills. This organization is not regulated by the Nebraska Department of Insurance. You should review this organization's guidelines carefully to be sure you understand any limitations that may affect your personal medical and financial needs.

New Hampshire Section 126-V:1

IMPORTANT NOTICE This organization is not an insurance company, and its product should never be considered insurance. If you join this organization instead of purchasing health insurance, you will be considered uninsured. By the terms of this agreement, whether anyone chooses to assist you with your medical bills as a participant of this organization will be totally voluntary, and neither the organization nor any participant can be compelled by law to contribute toward your medical bills. Regardless of whether you receive payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills. This organization is not regulated by the New Hampshire Insurance Department. You should review this organization's guidelines carefully to be sure you understand any limitations that may affect your personal medical and financial needs.

North Carolina Statute 58-49-12

Notice: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor its plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be voluntary. No other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally liable for the payment of your own medical bills.

APPENDIX C: LEGAL NOTICES

Pennsylvania 40 Penn. Statute Section 23(b)

Notice: This publication is not an insurance company nor is it offered through an insurance company. This publication does not guarantee or promise that your medical bills will be published or assigned to others for payment. Whether anyone chooses to pay your medical bills will be totally voluntary. As such, this publication should never be considered a substitute for insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always liable for any unpaid bills.

South Dakota Statute Title 58-1-3.3

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payments for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Texas Code Title 8, K, 1681.001

Notice: This health care sharing ministry facilitates the sharing of medical expenses and is not an insurance company, and neither its guidelines nor its plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the ministry or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this ministry continues to operate, you are always personally responsible for the payment of your own medical bills. Complaints concerning this health care sharing ministry may be reported to the office of the Texas attorney general.

Virginia Code 38.2-6300-6301

Notice: This publication is not insurance, and is not offered through an insurance company. Whether anyone chooses to assist you with your medical bills will be totally voluntary, as no other member will be compelled by law to contribute toward your medical bills. As such, this publication should never be considered to be insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always personally responsible for

APPENDIX C: LEGAL NOTICES

the payment of your own medical bills.

Wisconsin Statute 600.01 (1) (b) (9)

ATTENTION: This publication is not issued by an insurance company, nor is it offered through an insurance company. This publication does not guarantee or promise that your medical bills will be published or assigned to others for payment. Whether anyone chooses to pay your medical bills is entirely voluntary. This publication should never be considered a substitute for an insurance policy. Whether or not you receive any payments for medical expenses, and whether or not this publication continues to operate, you are responsible for the payment of your own medical bills.

This is NOT Insurance.

KROMODIMEDJO DECLARATION

EXHIBIT 5

2019 MEMBER GUIDE

AlieraCare™

BRONZE | SILVER | GOLD

INDIVIDUAL & FAMILY

Aliera™ HEALTHCARE

AlieraCare Plans are NOT Insurance.

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WELCOME

Welcome to Aliera Healthcare, Inc. | Trinity HealthShare. Thank you for becoming a member. We are committed to providing you and your family with unparalleled service and care at an affordable cost, and we pledge to keep our focus on what's most important – your overall health and wellness.

Please take a few minutes to review the information in this guide. The more informed you are, the easier it will be to get the care you need when you need it the most. Your membership card(s) and this booklet provide important information about your Plan, as well as the steps you need to take to access healthcare at one of the thousands of participating network provider locations. Your welcome information, Member Portal access and temporary member cards are contained in your Welcome Email: please print it and save a copy for reference.

If you have any questions about your Plan, activating your Membership Card, setting up your telemedicine account, Rx discount program, or accessing a healthcare provider, please contact a Member Care Specialist for assistance, **Monday through Friday, 8 a.m. to 8 p.m. ET at (844) 834-3456.**

MEMBER PORTAL

Username and password credentials are needed to enter the Member's portal to update payment or personal information. Visit www.alierahealthcare.com and click the Member Login tab. Your user name and password are on the Welcome Email sent at the time of initial enrollment. Member Services can send you a copy of this email following confirmation of identity.

CONTACT INFORMATION

For general information, account management, monthly contribution, or medical needs, please contact us:

Phone: 844-834-3456

Fax: 404-937-6557

Email: **memberservices@alierahealthcare.com** or **memberservices@trinityhealthshare.org**

Online: **www.alierahealthcare.com** or **www.trinityhealthshare.org**

Mail: PO Box 28220 Atlanta, GA 30358

DISCLAIMER

AlieraCare offering by Trinity HealthShare, through Aliera Healthcare, Inc., is a faith-based medical needs sharing membership. Medical needs are only shared by the members according to the membership guidelines. Our members agree to the Statement of Beliefs and voluntarily submit monthly contributions into a cost-sharing account with Trinity HealthShare, acting as a neutral clearing house between members. Organizations like ours have been operating successfully for years. We are including the following caveat for all to consider:

> This publication or membership is not issued by an insurance company, nor is it offered through an insurance company. This publication or the membership does not guarantee or promise that your eligible medical needs will be shared by the membership. This publication or the membership should never be considered as a substitute for an insurance policy. If the publication or the membership is unable to share in all or part of your eligible medical needs, or whether or not this membership continues to operate, you will remain financially liable for any and all unpaid medical needs.
>
> This is not a legally binding agreement to reimburse any member for medical needs a member may incur, but is instead, an opportunity for members to care for one another in a time of need, to present their medical needs to other members as outlined in the membership guidelines. The financial assistance members receive will come from other members' monthly contributions that are placed in a sharing account, not from Trinity HealthShare.

PLAN SERVICES & MEMBERSHIP AT A GLANCE

Aliera Healthcare services in conjunction with Trinity HealthShare cost-sharing creates a full range of services and offerings, each part summarized below:

PREVENTIVE CARE

As part of our solution, the plans cover medical services recommended by the USPSTF and outlined in the ACA for preventive care. There is zero out of pocket expense and zero obligation to reach the Member Shared Responsibility Amount (MSRA) for any scheduled preventive care service or routine in-network check-up, pap smear, flu shot and more. It's easier to stay healthy with regular preventive care.

PRIMARY CARE

Primary Care is at the core of an Aliera Plan, and we consider it a key step in living a healthier lifestyle. Our model is based on an innovative approach to care that is truly patient-centered, combining excellent service with a modern approach. This includes medical care needs such as primary care, office visits, sick care, and the general care of a member's day to day medical needs.

CHRONIC MAINTENANCE

With an AlieraCare Bronze, Silver, or Gold plan, members are eligible to receive chronic care management from their primary care physician for conditions such as diabetes, asthma, blood pressure, cardiac conditions, etc.

LABS & DIAGNOSTICS

Labs at in-network facilities are included.

TELEMEDICINE

With full 24/7 365-day access to a board-certified physician, it has never been simpler to stay healthy. You can contact them easily by phone or via video chat. If it's something minor such as a sinus infection, poison ivy or pink eye they can even send a prescription right over to your pharmacist.

PRESCRIPTION DRUG PROGRAM

The AlieraCare Bronze, Silver, or Gold prescription savings program delivers significant discounts for a variety of drugs (depending on prescription), saving members an average of 55% on prescription drug purchases. After $1,500 of prescription drug expenditures through Rx Valet, members are eligible for a percentage of reimbursement for preferred and mail order drugs. Maximum reimbursement of $4,000 per plan year. See Appendix for details.

URGENT CARE

For those medical situations that can't wait or are more complex than primary care services, AlieraCare Bronze, Silver, and Gold plans offer access to Urgent Care facilities at hundreds of medical centers throughout the United States.

MEMBERSHIP

Trinity HealthShare is a health care sharing ministry (HCSM) which acts as an organizational clearing house to administer sharing contributions across qualifying members healthcare needs. The AlieraCare membership is NOT health insurance. The membership is based on a religious tradition of mutual aid, neighborly assistance, and burden sharing. The membership does not subsidize self-destructive behaviors and lifestyles, but is specifically tailored for individuals who maintain a healthy lifestyle, make responsible choices in regards to health and care, and believe in helping others. Because Trinity HealthShare is a religious organization, members are required to agree with the organizations Statement of Beliefs; see Part II of this guide for the full description and membership details.

SPECIALTY CARE

For most everyday medical conditions, your PCP is your one-stop medical shop. However, there are cases when it's time to see a specialist who's had additional education and been board certified for that specialty. For situations like these, the AlieraCare Bronze, Silver, and Gold plans provides specialty care offerings at the cost of just a consult fee. A member will need to receive a PCP referral to see a specialist for treatment or consultation outside of their scope of knowledge.

HOSPITALIZATION

Hospitalization is eligible, once the Member Shared Responsibility Amount has been met, under all the individual plans.

SURGERY

Both in-patient and out-patient procedures are eligible, once the Member Shared Responsibility Amount has been met, under all individual plans.

EMERGENCY ROOM

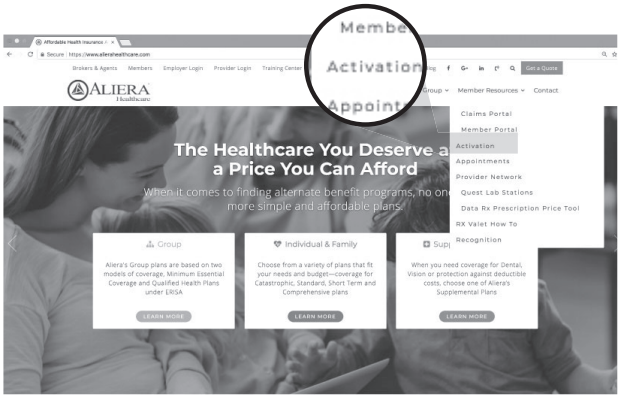
An emergency is defined as treatment that must be rendered to the patient immediately for the alleviation of the sudden onset of an unforeseen illness or injury that, if not treated, would lead to further disability or death. Examples of an emergency include, but are not limited to, severe pain, choking, major bleeding, heart attack, or a sudden, unexplained loss of consciousness.

GETTING STARTED

WHAT DOES IT MEAN?

Many of the terms used in describing health cost-sharing may be unfamiliar to those new to the programs and plans provided by Aliera and Trinity. Please refer to the Definition of Terms section for a quick and easy understanding of terms used in this guide and other plan documents.

1. **Activate Your Membership**
   On or after your effective date, visit **www.alierahealthcare.com** to securely enter your information. Click the Activation tab on the navigation bar and follow the instructions. **If you require assistance, contact a Member Care Specialist toll-free at (844) 834-3456 or email memberservices@alierahealthcare.com**.

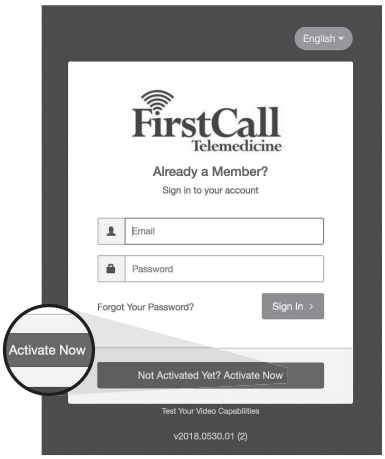


2. **Set Up Your Telemedicine Account**
   Follow the steps below to set up your telemedicine account. If you have not activated your Membership Card, or if your Membership fees are not paid up to date, you are not eligible to set up your telemedicine account.

   - Set up your account (Primary Member)
     Visit **www.firstcalltelemed.com,** click "Activate Now." Follow the online instructions and provide the required information, including your medical history.

   - Set up minor dependents (17 years or younger)
     Log in to your account and click "My Family" on the top menu. Follow the online instructions to provide the necessary information and complete your dependent's medical history.

   - Set up adult dependents (18 – 26 years)
     Adult dependents must set up their own account. Visit the website and click "Set up account." Follow the online instructions to provide the required information and to complete your medical history.



3. **Set Up Your Prescription Discount Account**
   Follow the steps below to set up your prescription discount account. If you have not activated your Membership Card, or if your Membership fees are not paid up to date, you are not eligible to set up your prescription discount account.

   Please go to **www.myrxvalet.com/memberlogin.php**

   1. Enter your Member ID that is located on your Aliera Healthcare ID card
   2. For your Group ID type in Aliera
   3. Complete your profile for yourself and any dependents

   After registration is complete, you will receive an email with instructions and a video on how to use Rx Valet for home delivery and at your local pharmacy.

   Please download the Rx Valet APP on your smartphone at your convenience.

   If you are experiencing an urgent situation and don't have time to set up your account, you can hand your Aliera card to the pharmacist to receive your medication. The discount will not be as great, so please set up your account when you have time.

   Home Delivery Prescription Information:

   - Home Delivery orders are fulfilled exclusively through Advanced Pharmacy, LLC. To save time, have your physician send your prescription directly to Advanced Pharmacy electronically.
   - Alternatively, they can also transfer your existing prescriptions from another pharmacy to fulfill your order. Please call their live Customer Care Team at 1-855-798-2538 and provide the medication details, pharmacy name, and pharmacy telephone number.
   - Electronic prescriptions should be sent to Advanced Pharmacy, LLC located at **350-D Feaster Road Greenville, SC 29615**.
     Phone: 855-240-9368 **Fax: 888-415-7906**
     NPI: 1174830475 **NCPDP: 4229971**

4. **Review Your Offerings**
   This guide contains the information you need to understand each offering available with your Plan. Keep your Member Card with you at all times; the contact number for your telemedicine provider is printed on your card. It is highly encouraged to contact your telemedicine provider before seeking medical attention.

PART I : HOW TO USE YOUR MEMBERSHIP

TELEMEDICINE

More than 80% of primary medical conditions can be resolved by your telemedicine provider. It is always encouraged that members contact their telemedicine provider first for quick, convenient medical assistance. The contact information for your telemedicine provider is found on your member card. Instructions are also found on the back of your Welcome Letter, as well as on our web site, under Member Resources.

Offerings of the Telemedicine Program

- At home, at work, or while traveling in the US, speak to a telemedicine doctor from anywhere, anytime, on the go.
- 24/7 access to a doctor via face-to-face internet consultation or by phone is available for you and dependents on your Plan.
- Speak with the next available doctor or schedule an appointment for a more convenient time.
- Telemedicine doctors typically respond within 15 minutes of your call.
- Save time and money by avoiding expensive emergency room visits, waiting for an appointment, or driving to a local facility.
- Telemedicine consultations are free for you and dependents on your Plan.
- Telemedicine providers can treat conditions such as:
  - Cold and flu symptoms
  - Bronchitis
  - Allergies
  - Poison ivy
  - Pink eye
  - Urinary tract infections
  - Respiratory infections
  - Sinus problems
  - Ear infections, and more

Antibiotics are not always the answer to treat a medical condition. Doctors may choose not to prescribe antibiotics for viral illnesses such as common colds, sore throats, coughs, sinus infections, and the flu.

If the telemedicine doctor recommends that you see your PCP or visit an urgent care facility, contact Aliera's Concierge Service, and a member care specialist will be happy to assist you with scheduling an appointment.

PREVENTIVE CARE

It's easier to stay healthy when you have regular preventive care. Members have no out-of-pocket expenses for preventive services, which include, but are not limited to, routine in-network checkups, pap smears, flu shots and more.

HOW TO USE PREVENTIVE SERVICES

1. Download the Preventive Healthcare Guidebook from the link found in your Welcome email or visit us online at **www.alierahealthcare.com** or **www.trinityhealthshare.org**.
2. Members do not need to call their telemedicine provider to schedule preventive care.
3. Upon arrival at a PCP, please present your Membership Card and one photo ID. The front desk admin will check your eligibility status. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not share the costs of the provider.
4. Preventive health services must be appropriate for the eligible person and follow the guidelines below:
   - **A.** In general – those of the U.S. Preventive Services Task Force that have an A or B rating.
   - **B.** For immunizations – those of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
   - **C.** For preventive care and screenings for children and adolescents – those of the Health Resources and Services Administration.
   - **D.** For preventive care and screenings for women – those of the Health Resources and Services Administration that are not included in section (A) of the U.S. Preventive Services Task Force schedule.

LABS AND DIAGNOSTICS

Aliera and Trinity Members have access to lab work in the convenience of their in-network provider's office or at any lab location nationwide.

URGENT CARE

Your membership raises the standard of healthcare available to you by putting individuals first, treating them with clinical excellence, and focusing on their well-being. Members can access services from hundreds of Urgent Care network facilities throughout the United States.

- AlieraCare Bronze, Silver, and Gold plans have unlimited Urgent Care visits.
- See Appendix for your specific plan details.
- X-rays are included, and subject to $25 per read fee at Urgent Care.

HOW TO USE THE URGENT CARE SERVICE

1. Call 911 if your emergency is life threatening; otherwise, please contact your telemedicine provider first via telephone or a scheduled face-to-face internet conference. Your provider will determine if your medical condition can be resolved without visiting a local urgent care facility.
2. If your medical issue cannot be resolved after your free consultation with a telemedicine doctor, visit the closest in-network Urgent Care facility.
3. Upon arrival at an Urgent Care facility, present your Membership Card and one photo ID. The front desk admin will check your eligibility status. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the provider.
4. At time of service, payment of $20 (on average) is due for the consultation, and a $25 per read fee for X-rays if needed may be due. Costs may be higher depending on your state and provider.

IF URGENT CARE SERVICES ARE UNAVAILABLE

If an in-network Urgent Care facility is unavailable to a Member requiring immediate Urgent Care, please adhere to the following procedure:

1. Visit **www.alierahealthcare.com**. Click “Network” to find the nearest urgent care facility under MultiPlan.

2. If the nearest in-network facility is more than 20 miles away from the Member, is closed (after 6:00 p.m.), or is no longer in business, the Member should seek out the nearest Urgent Care facility, hospital, or emergency room to receive urgent medical attention.

3. AlieraCare products are not health insurance plans and Aliera nor Trinity are responsible for payment to out-of-network Urgent Care facility, hospital, or emergency room. The Member is solely responsible for such urgent care medical payments. Aliera and or Trinity maintain an allotment fund designed to provide a Member with supplemental payment assistance (ex gratia) in the amount of $105.00 to offset the cost incurred at an out-of-network Urgent Care or Hospital emergency room facility. This monetary assistance is limited to one visit per year, per Member. Payment is made directly to the Member after confirmation of submitted proof of urgent care necessity and unavailability of an in-network provider.

PRIMARY CARE

PRIMARY CARE FOR SICK CARE

In addition to our urgent care services, many of our plans offer Members under the age of 65 episodic primary care or sick care.

- AlieraCare Bronze, Silver, and Gold plans have unlimited Primary Care visits.
- Annual Physicals are available immediately.
- For convenience, some clinics are open evenings and weekends.

HOW TO USE PRIMARY CARE SERVICE FOR SICK CARE

1. Contact your telemedicine provider to speak with a U.S. board-certified doctor via telephone or a scheduled face-to-face internet conference.
2. The telemedicine doctor may be able to resolve your medical issue and prescribe medication if needed. More than 80% of primary medical conditions can be resolved by your telemedicine provider.
3. If your medical issue cannot be resolved after a no fee consultation with the telemedicine doctor, visit the closest in-network Primary Care facility.
4. Upon arrival at a clinic, present your Membership Card and one photo ID. The front desk admin will check your eligibility status before you can see a provider. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the provider.
5. At the time of service, a consult fee is due for the consultation, and a $25 per read fee for X-rays if needed. Costs may be higher depending on your state and provider.

SPECIALTY CARE

AlieraCare members are required to obtain referrals to visit a specialist, except for women in need of gynecological care for routine medical needs. Specialty visits have a consult fee at the time of service.

HOSPITALIZATION

Your hospitalization cost-sharing is provided to you in an effort to alleviate the stress and strain during times of crisis or medical needs.

1. Members are required to pre-authorize all hospitalization services and visits unless it is an obvious medical emergency. Please see pre-authorization section for instructions.
2. The member will be responsible for first reaching their MSRA before any cost-sharing will be available. Once the MSRA has been reached in full, the sharing will then be reimbursed directly back to the providers and hospital facilities.
3. Several plans allow for fixed cost-sharing in the emergency room. Please see Appendix for your exact plan details.

PPO NETWORK

With a growing nationwide PPO network of more than 1,000,000 healthcare professionals and more than 6,000 facilities, Multiplan PHCS network offers Plan Members a range of quality choices to help them stay healthy.

- Search for providers by distance, cost efficiency, and specialty.

FIND A NETWORK HEALTHCARE PROFESSIONAL

- Visit **www.alierahealthcare.com**.
- Hover over the Member Resources tab.
- Click on Provider Network.
- Click on the Medical Provider logo associated with your plan.
- Search for a provider by Zip Code, City, County, State, or other search criteria.

Call Aliera Healthcare at (844) 834-3456 OR
Trinity HealthShare at (844) 763-5338.

Select the Provider Coordination Department and a care coordinator will help you navigate the healthcare process effectively and efficiently.

PART II : HOW YOUR HEALTHCARE COST-SHARING MINISTRY (HCSM) WORKS

Trinity HealthShare is a clearing house that administers voluntary sharing of healthcare needs for qualifying members. The membership is based on a tradition of mutual aid, neighborly assistance, and burden sharing. The membership does not subsidize self-destructive behaviors and lifestyles, but is specifically tailored for individuals who maintain a healthy lifestyle, make responsible choices in regards to health and care, and believe in helping others. The Trinity HealthShare membership is not health insurance.

Guidelines Purpose and Use

The HCSM guidelines are provided as an outline for eligible needs in which contributions are shared in accordance with the membership's clearing house instructions. They are not for the purpose of describing to potential contributors the amount that will be shared on their behalf and do not create a legally enforceable right on the part of any contributor. Neither these guidelines nor any other arrangement between contributors and Trinity HealthShare creates any rights for any contributor as a reciprocal beneficiary, as a third-party beneficiary, or otherwise.

The edition of the guidelines in effect, on the date of medical services, supersedes all previous editions of the guidelines and any other communication, written or verbal. With written notice to the general membership, the guidelines may change at any time based on the preferences of the membership and on the decisions, recommendations, and approval of the Board of Trustees.

An exception to a specific provision only modifies that provision and does not supersede or void any other provisions.

Individuals Helping Individuals

Contributors participating in the membership help individuals with their medical needs. Trinity HealthShare facilitates in this assistance and acts as an independent and neutral clearing house, dispersing monthly contributions as described in the membership instructions and guidelines.

MEMBERSHIP QUALIFICATIONS

To become and remain a member of Trinity HealthShare, a person must meet the following criteria:

Religious Beliefs and Standards. The person must have a belief of helping others and/or maintaining a healthy lifestyle as outlined in the Statement of Beliefs contained in the membership application. If at any time during participation in the membership, the individual is not honoring the Statement of Beliefs, they will be subject to removal from participating in the membership.

Medical History. The person must meet the criteria to be qualified for a membership on his/her application date, based on the criteria set forth in this guidebook and the membership application.

If, at any time, it is discovered that a member did not submit a complete and accurate medical history on the membership application, the criteria set forth in the Membership Eligibility Manual on his/her application date will be applied, and could result in either a retroactive membership limitation or a retroactive denial to his/her effective date of membership.

Members may apply to have a membership limitation removed by providing medical evidence that they qualify for such removal according to the criteria set forth in the Membership Eligibility Manual. Membership limitations and denials can be applied retroactively but cannot be removed retroactively.

Application, Acceptance, and Effective Date. A person must submit a membership application and be accepted into the membership by meeting the criteria of the Member Eligibility Manual. The membership begins on a date specified by Trinity HealthShare in writing to the member.

Dependent(s). A dependent may participate under a combined membership with the head of household.

A dependent wishes to continue participating in the membership but no longer qualifies under a combined membership must apply and qualify for a membership based on the criteria set forth in the Membership Eligibility Manual.

Under a combined membership, the head of household is responsible for ensuring that everyone participating under the combined membership meets and complies with the Statement of Beliefs and all guideline provisions.

Financial Participation. Monthly contributions are requested to be received by the 1st or 15th of each month depending on the member's effective date. If the monthly contribution is not received within 5 days of the due date, an administrative fee may be assessed to track, receive, and post the monthly contribution. If the monthly contribution is not received by the end of the month, a membership will become inactive as of the last day of the month in which a monthly contribution was received.

Any member who has a membership that has become inactive will be able to reapply for membership under the terms outlined to them in writing by Trinity HealthShare. A member will not be able to reapply for membership if their account has been made inactive a total of three times.

Needs occurring after a member's inactive date and before they reapply are not eligible for sharing.

When Available Shares are less than Eligible Needs. In any given month, the available suggested share amounts may or may not meet the eligible needs submitted for sharing. If a member's eligible bills exceed the available shares to meet those needs, the following actions may be taken:

1. A pro-rata sharing of eligible needs may be initiated, whereby the members share a percentage of eligible medical bills within that month and hold back the balance of those needs to be shared the following month.

2. If the suggested share amount is not adequate to meet the eligible needs submitted for sharing over a 60-day period, then the suggested share amount may be increased in sufficient proportion to satisfy the eligible needs. This action may be undertaken temporarily or on an ongoing basis.

Other Criteria. Children under the age of 18 may not qualify for their own membership. Non-U.S. citizens may qualify for membership as determined by Trinity HealthShare on a case-by-case basis.

MONTHLY CONTRIBUTIONS

Monthly contributions are voluntary contributions or gifts that are non-refundable. As a non-insurance membership, neither Trinity HealthShare nor the membership are liable for any part of an individual's medical need. All contributors are responsible for their own medical needs. Although monthly contributions are voluntary contributions or gifts, there are administrative costs associated with monitoring the receipt and disbursement of such contributions or gifts. Therefore, declined credit cards, returned ACH payments, or any contribution received after the members reoccurring active date may incur an administrative fee.

IMPORTANT INFORMATION ABOUT PLAN CHANGES:

Members wishing to change to a membership type other than that which they are currently participating may, at the discretion of Trinity HealthShare, be required to submit a new signed and dated membership application for review. Membership type changes can only become effective on the first of the month after the new membership application has been approved.

1. When switching from one annual product category to another (i.e. AlieraCare to Trinity HealthShare's CarePlus Advantage) your plan will be reset as if it is a new enrollment. This rule does not apply when transitioning from an InterimCare plan.

2. You are allowed two plan changes per membership year. The first is free of cost, the second will incur the application fee of the desired product.

Contributors wishing to discontinue participation in the membership must submit the request in writing by the 20th day of the month before which the contributions will cease. The request should contain the reason why the contributor is discontinuing participation in the membership. Should the contributor fail to follow these guidelines as they pertain to discontinuing their participation in the membership and later wish to reinstate their membership, unsubmitted contributions from the prior participation must be submitted with a new application.

A member is not eligible for cost-sharing when a member:

A. Receives care within the first 60 days of the plan and cancels membership within 30 days of receiving medical care; except within the last 90 days of the membership term;

B. Receives or requires surgery within the first 60 days of becoming a member except in the case of an accident.

EARLY VOLUNTARY TERMINATION

Members of the Trinity HealthShare may terminate their membership at any time, with 30 days prior notice. Trinity HealthShare plans are not a substitute for "short term medical plans". Medical expenses incurred during the term of the membership and followed by early voluntary termination within 90 days of incurring medical expenses, will be reviewed and may not be eligible for cost-sharing, where the early termination was not as a direct result of affordability issues with the health sharing program.

STATEMENT OF BELIEFS

At the core of what we do, and how we relate to and engage with one another as a community of people, is a set of common beliefs. Our Statement of Shared Beliefs is as follows:

1. We believe that our personal rights and liberties originate from God and are bestowed on us by God.
2. We believe every individual has a fundamental religious right to worship God in his or her own way.
3. We believe it is our moral and ethical obligation to assist our fellow man when they are in need per our available resources and opportunity.
4. We believe it is our spiritual duty to God and our ethical duty to others to maintain a healthy lifestyle and avoid foods, behaviors, or habits that produce sickness or disease to ourselves or others.
5. We believe it is our fundamental right of conscience to direct our own healthcare in consultation with physicians, family, or other valued advisors.

DEFINITION OF TERMS

Terms used throughout the Member Guide and other documents are defined as follows:

Affiliated Practitioner. Medical care professionals or facilities that are under contract with a network of providers with whom Trinity HealthShare works. Affiliated providers are those that participate in the PHCS network. A list of providers can be found at **http://www.multiplan.com**.

Application Date. The date Trinity HealthShare receives a complete membership application.

Combined Membership. Two or more family members residing in the same household.

Contributor. Person named as head of household under the membership.

Dependent. The head of household's spouse or unmarried child(ren), under the age of 20 or 26 if a full-time student, who are the head of household's dependent by birth, legal adoption, or marriage who is participating under the same combined membership.

Eligible. Medical needs that qualify for voluntary sharing of contributions from escrowed funds, subject to the sharing limits.

Escrow Instructions. Instructions contained on the membership application outlining the order in which voluntary monthly contributions may be shared by Trinity HealthShare.

Guidelines. Provided as an outline for eligible medical needs in which contributions are shared in accordance with the membership's escrow instructions.

Head of Household. Contributor participating by himself for herself; or the husband or father that participates in the membership; or the wife or mother that participates in the membership. The Head of Household is the oldest member on the plan.

Licensed Medical Physician. An individual engaged in providing medical care and who has received state license approval as a practicing Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

Medically Necessary. A service, procedure, or medication necessary to restore or maintain physical function and is provided in the most cost-effective setting consistent with the member's condition. Services or care administered as a precaution against an illness or condition or for the convenience of any party are not medically necessary. The fact that a provider may prescribe, administer, or recommend services or care does not make it medically necessary, even if it is not listed as a membership limitation or an ineligible need in these guidelines. To help determine medical necessity, Trinity HealthShare may request the member's medical records and may require a second opinion from an affiliated provider.

Member(s). A person(s) who qualifies to receive voluntary sharing of contributions for eligible medical needs per the membership clearing house instructions, guidelines, and membership type.

Member Shared Responsibility Amounts (MSRA). The amounts of an eligible need that do not qualify for sharing because the member is responsible for those amounts.

Membership. All members of Trinity HealthShare.

Membership Eligibility Manual. The reference materials that contain the criteria used to determine if a potential member is eligible for participation in the membership and if any membership limitations apply.

Membership Type. HCSM sharing options are available with different member shared responsibility amounts (MSRA) and sharing limits as selected in writing on the membership application and approved by Trinity HealthShare.

Monthly Contributions. Monetary contributions, excluding the annual membership fee, voluntarily given to Trinity HealthShare to hold as an escrow agent and to disburse according to the membership escrow instructions.

Need(s). Charges or expenses for medical services from a licensed medical practitioner or facility arising from an illness or accident for a single member.

Non-affiliated Practitioner. Medical care professionals or facilities that are not participating within our current network.

Pre-existing Condition. Any illness or accident for which a person has been diagnosed, received medical treatment, been examined, taken medication, or had symptoms within 24 months prior to the effective date. Symptoms include but are not limited to the following: abnormal discharge or bleeding; abnormal growth/break; cut or tear; discoloration; deformity; full or partial body function loss; obvious damage, illness, or abnormality; impaired breathing; impaired motion; inflammation or swelling; itching; numbness; pain that interferes with normal use; unexplained or unplanned weight gain or loss exceeding 25% of the total body weight occurring within a six-month period; fainting, loss of consciousness, or seizure; abnormal results from a test administered by a medical practitioner.

Usual, Customary and Reasonable (UCR). The lesser of the actual charge or the charge most other providers would make for those or comparable services or supplies, as determined by Trinity HealthShare.

CONTRIBUTORS' INSTRUCTIONS AND CONDITIONS

By submitting monthly contributions, the contributors instruct Trinity HealthShare to share clearing house funds in accordance with the membership instructions. Since Trinity HealthShare has nothing to gain or lose financially by determining if a need is eligible or not, the contributor designates Trinity HealthShare as the final authority for the interpretation of these guidelines. By participation in the membership, the member accepts these conditions.

PART III : YOUR SUMMARY OF COST-SHARING

ELIGIBLE MEDICAL EXPENSES*

Medical costs are shared on a per person per incident basis for illnesses or injuries incurring medical expenses after the membership effective date when medically necessary and provided by or under the direction of licensed physicians, osteopaths, urgent care facilities, clinics, emergency rooms, or hospitals (inpatient and outpatient), or other approved providers. Unless otherwise limited or excluded by these Guidelines, medical expenses eligible for sharing include, but are not limited to, physician and hospital services, emergency medical care, surgical procedures, medical testing, x-rays, ambulance transportation, and prescriptions.

**See the Appendix for other limits and conditions of sharing by plan*

1. **Allergy Office Visits and Testing**
2. **Ambulance.** Emergency land or air ambulance transportation to the nearest medical facility capable of providing the medically necessary care to avoid seriously jeopardizing the sharing member's life or health. Air transportation is limited to $10,000.
3. **Anesthesiologist Services**
4. **B12 Injections.** Eligible at a PCP or Specialist only.
5. **Birthing Center.** Eligible after MSRA.
6. **Cancer.** Cancer sharing eligibility is available immediately for new occurrences of cancer. Any pre-existing or recurring cancer condition is not eligible for sharing. Cancer sharing will not be available for individuals who have cancer at the time of or five (5) years prior to application. If cancer existed outside of the 5-year time frame of a pre-existing look-back, the following must be met in the five (5) years prior to application, to be eligible for future, non-recurring cancer incidents. 1. The condition had not been treated nor was future treatment prescribed/planned; 2. The condition had not produced harmful symptoms (only benign symptoms); 3. The condition had not deteriorated. Cancer is limited to a maximum per term of $500,000 when applicable.

7. **Cardiac Rehabilitation.** Eligible after MSRA.

8. **Chemotherapy.** Subject to cancer limitations.

9. **Chronic Maintenance.** Chronic maintenance is eligible when a member has chosen a plan with chronic maintenance specifically included and a listing of the maximum number of allowable visits. See 'Appendix' attached hereto.

10. **Diagnostic Lab & Pathology.** Eligible after MSRA.

11. **Diagnostic Lab & Radiology.** Eligible after MSRA.

12. **Emergency Room.** Emergency room services for stabilization or initiation of treatment of a medical emergency condition provided on an outpatient basis at a hospital, clinic, or Urgent Care facility, including when hospital admission occurs within twenty-three (23) hours of emergency room treatment.

13. **Eye Care.** Limited to medical necessity and accident only. Excludes cosmetic, frames, lenses, contacts, extensive eye exams and subject to pre-existing limitations.

14. **Home Health Care.** Eligible after MSRA.

15. **Home Infusion Services.** Eligible after MSRA.

16. **Hospice Services.** Eligible after MSRA.

17. **Hospitalization.** Hospital charges for inpatient or outpatient hospital treatment or surgery for a medically diagnosed condition.

18. **Maternity.** AlieraCare Bronze, Silver, and Gold plans have full maternity offerings. Medical expenses for maternity ending in a delivery by emergency cesarean section that are medically necessary, are eligible for sharing up to $8,000, subject to the applicable Member Shared Responsibility Amount. Medical expenses for a newborn arising from complications at the time of delivery, including, but not limited to, premature birth, are treated as a separate incident and limited to $50,000 of eligible sharing, subject to the Member Shared Responsibility Amount.

19. **Mental Health.** Plan holders are eligible for $2,500 (max) for Psychotherapy office visits and $1,000 (max) at out-patient facilities. Excludes in-patient and residential settings.

20. **Occupational Therapy.** Up to six (6) visits per membership year for occupational therapy.

21. **Organ Transplant Limit.** Eligible needs requiring organ transplant may be shared up to a maximum of $150,000 per member. This includes all costs in conjunction with the actual transplant procedure. Needs requiring multiple organ transplants will be considered on a case-by-case basis.

22. **Physical Therapy.** Up to six (6) visits per membership year for physical therapy by a licensed physical therapist.

23. **Podiatry Services.** Eligible after MSRA.

24. **Preadmission Testing.** Eligible after MSRA.

25. **Prescription Drugs.** The AlieraCare plan includes a service by RX Valet, which includes discounts for prescription drugs. See Appendix for details.

26. **Preventive.** Most programs from either Trinity or Aliera provide everyone with the necessities of the 64 preventive care services as outlined by the United States Preventive Task force. (Excludes CarePlus Advantage.) Preventive care includes the PCP office visit and does not require a co-expense or consult fee.

27. **Primary Care.** Depending on your plan choice, primary care is at the core of preventing medical issues from escalating into a more catastrophic need. See Appendix for the specific plan details.

28. **Pulmonary Rehab**

29. **Radiation Therapy.** Subject to cancer limitations.

30. **Retail Walk in Clinics.** Subject to specialty consult fee based on plan chosen. See Appendix for details.

31. **Routine Hearing Exams.** At Primary Care (PCP) only.

32. **Routine Nursing Care of Newborn Infant.** Eligible after MSRA.

33. **Skilled Nursing Facility.** Eligible after MSRA.

34. **Sleep Disorders.** Overnight Sleep Testing Limit: All components of a polysomnogram must be completed in one session. A second overnight test will not be eligible for sharing under any circumstance. Overnight sleep testing must be medically necessary and will require pre-authorization. Allowed charges will not exceed the Usual, Customary, and Reasonable charges for the area.

35. **Smoking Cessation.** Members who have acknowledged they smoke and made an additional contribution are provided the opportunity to obtain free smoking cessation medication and counseling through the eligible preventive services.

36. **Specialty Care.** For most everyday medical conditions, your PCP is your one-stop medical shop. However, there are cases when it's time to see a specialist who's had additional education and been board certified for that specialty. For situations like these, the AlieraCare Bronze, Silver, and Gold plans provides specialty care offerings at the cost of just a consult fee. A member will need to receive a PCP referral to see a specialist for treatment or consultation outside of their scope of knowledge.

37. **Speech Therapy.** Up to six (6) visits per membership year. Only applicable after a stroke.

38. **Surgical Offerings.** Non-life-threatening surgical offering are not available for the first 60 days of membership. Please verify eligibility by calling Member Services before receiving any surgical services.

39. **Telemedicine.** Telemedicine is included in all AlieraCare programs offered by Trinity HealthShare and Aliera Healthcare as your first line of defense. Your membership provides you and your family 24/7/365 access to a U.S. Board certified medical doctor.

40. **Urgent Care.** If your plan provides cost-sharing for Urgent Care, you will have the added benefit of enjoying the ability to choose an Urgent Care facility in lieu of an emergency room. See the Appendix for any urgent care options and any limitations to plan.

41. **X-rays.** X-rays listed on your plan details in the Appendix are for imaging services at PCP or Urgent Care facilities only and require a $25 read fee per view at time of service. Your MSRA will apply to all other x-rays. MRI, CT Scans and other diagnostics must be paid with your MSRA before cost-sharing is provided.

**Medical Expense Incident is any medically diagnosed condition receiving medical treatment and incurring medical expenses of the same diagnosis. All related medical bills of the same diagnosis comprise the same incident. Such expenses must be submitted for sharing in the manner and form specified by Trinity HealthShare. This may include, but not be limited to, standard industry billing forms (HCFA1500 and/or UB 92) and medical records. Members share these kinds of costs.*

LIMITS OF SHARING

Total eligible needs shared from member contributions are limited as defined in this section and as further limited in writing to the individual member.

1. **Lifetime Limits.** $1,000,000: the maximum amount shared for eligible needs over the course of an individual member's lifetime.

2. **Per Incident.** The occurrence of one particular sickness, illness, or accident.

3. **Cancer Limits when applicable.** Cancer is limited to a maximum per term of $500,000 when applicable.

4. **Member Shared Responsibility Amounts (MSRA).** Eligible needs are limited to the amounts in excess of the MSRA, which are applied per individual member per the plan year. MSRA(s). The eligible amount that does not qualify for sharing based on the membership type chosen by the member.

5. **Non-Affiliated Practitioner.** Services rendered by a non-affiliated practitioner will not be eligible for sharing nor will any amount be applied to your MRSA unless specified differently in the plan details contained herein.

COST-SHARING FOR PRE-EXISTING CONDITIONS

Bronze Program cost-sharing parameters for pre-existing conditions. The following restrictions are only applicable to a pre-existing condition and do not affect normal sharing for other non-pre-existing related incidents, events, etc.

1. Chronic or recurrent conditions that have evidenced signs/symptoms and/or received treatment and/or medication within the past 24 months are not eligible for sharing during the first 24 months of membership.

2. Upon inception of the 25th month of continuous membership and thereafter, the condition may no longer be subject to the pre-existing condition sharing limitations.

3. Appeals may be considered for earlier sharing in surgical interventions when it is in the mutual best interest of both the members and the membership to do so.

Silver Program cost-sharing parameters for pre-existing conditions. The following restrictions are only applicable to a pre-existing condition and do not affect normal sharing for other non-pre-existing related incidents, events, etc.

1. During the first two years of continuous membership, sharing is available up to $10,000 of total medical expenses incurred for pre-existing conditions per year, after a separate MSRA equal to two times your plan MSRA.

2. Upon inception of the 25th month of continuous membership and thereafter, the condition may no longer be subject to the pre-existing condition sharing limitations.

3. Appeals may be considered for earlier sharing in surgical interventions when it is in the mutual best interest of both the members and the membership to do so.

Gold Program cost-sharing parameters for pre-existing conditions. The following restrictions are only applicable to a pre-existing condition and do not affect normal sharing for other non-pre-existing related incidents, events, etc.

1. During the first two years of continuous membership, sharing is available up to $20,000 of total medical expenses incurred for a pre-existing condition per year, after a separate MSRA equal to two times your plan MSRA.

2. Upon the inception of the 25th month of continuous membership and thereafter, the condition may no longer be subject to the pre-existing condition sharing limitations.

3. Appeals may be considered for earlier sharing in surgical interventions when it is in the mutual best interest of both the members and the membership to do so.

Other Resources. Offerings available to the member from other sources such as insurance, VA, Tricare, private grants, or by a liable third party (primary, auto, home insurance, educational, etc.), will be considered the member's primary benefit source, and the member will be required to file medical claims with those providers first. If there are medical expenses that those sources do not pay, the member is authorized to submit the excess medical expenses for sharing, and the MSRA will be waived, up to the maximum MSRA as defined in the member's plan. The MSRA will only be waived if a third party source pays on the member's behalf. Sharing of monthly contributions for a need that is later paid, or found to payable by another source will automatically allow Trinity HealthShare full rights to recover the amounts that were shared with the member.

MEDICAL EXPENSES NOT GENERALLY SHARED BY HCSM

Only needs incurred on or after the membership effective date are eligible for sharing under the membership instructions. The member (or the member's provider) must submit a request for sharing in the manner and format specified by Trinity HealthShare. This includes, but is not limited to, a Need Processing Form, standard industry billing forms (HCFA 1500 and/or most recent UB form), and may include medical records. All participating members have a responsibility to abide by the Members' Rights and Responsibilities published by Trinity HealthShare and are included at the end of these guidelines.

Needs arising from any one of the following are not eligible for sharing under the membership clearing house instructions:

1. Abortion Services
2. Acupuncture Services
3. Aqua Therapy
4. Biofeedback
5. Birth Control (Male) Elective Sterilization
6. Birth Control (Male) Reversal of Sterilization
7. Cataract Contacts or Glasses
8. Chemical Face Peels
9. Chiropractic Services
10. Christian Science Practitioner
11. Cochlear Devices
12. Cosmetic Surgery
13. Custodial Care Services
14. Dental Services
15. Dermabrasion Services
16. Diabetic Insulin, Supplies, and Syringes

17. Doula
18. Durable Medical Equipment
19. Education Services
20. Exercise Equipment
21. Experimental Drugs
22. Experimental Procedures
23. Extreme sports: Sports that voluntarily put an individual in a life-threatening situation. Sports such as but not limited to “free climb” rock climbing, parachuting, fighting, martial arts, racing, cliff diving, powerboat racing, air racing, motorcycle racing, extreme skiing, wingsuit, and similar.
24. Gender Dysphoria
25. Gender Dysphoria Office Visit – PCP
26. Gender Dysphoria Office Visit – Specialist
27. Genetic Testing
28. Group Therapy Services
29. Hemodialysis
30. Hypnotherapy Services
31. Infertility Diagnostic or treatment
32. Infertility Services
33. Investigational Drugs/Procedures
34. Lifestyles or activities engaged in after the application date that conflicts with the Statement of Beliefs (on the membership application).
35. Massage Therapy
36. Midwifery
37. MILIEU Situational Therapy Services
38. Morbid Obesity

39. Non- Routine Hearing Exams & Hearing Aids
40. Nurse Practitioner
41. Orthopedic Shoes
42. Orthotics (back, neck, knee, wrist, etc.)
43. Pain Management
44. Personal aircraft includes hang gliders, parasails, ultra-lights, hot air balloons, sky/diving, and any other aircraft not operated by a commercially licensed public carrier.
45. Personal Convenience Items
46. Post-Surgical Bras
47. Private Duty Nursing Services
48. Professional Sports Injuries
49. Prosthetic Appliances
50. Robotic Surgery
51. Self-Inflicted Injury
52. Sexual Dysfunction Services
53. Sexual Transformation Services
54. Substance Abuse
55. Surgical Stockings
56. Treatment or referrals received or obtained from any family member including, but not limited to, father, mother, aunt, uncle, grandparent, sibling, cousin, dependent, or any in-laws.

PRE-AUTHORIZATION REQUIRED

Non-Emergency Surgery, Procedure, or Test. The member must have the following procedures or services pre-authorized as medically necessary prior to receiving the service. Failure to comply with this requirement will render the service not eligible for sharing.

Hospitalizations. Non-emergency prior to admission; emergency visits notification to Trinity HealthShare within 48 hours.

- MRI studies/CT scans/Ultrasounds
- Sleep studies must be completed in one session
- Physical or occupational therapy
- Speech therapy under limited circumstances only
- Cardiac testing, procedures, and treatments
- In-patient cancer testing, procedures, and treatments
- Infusion therapy within facility
- Nuclide studies
- EMG/EEG
- Ophthalmic procedures
- ER visits, emergency surgery, procedure, or test:
  Non-emergency use of the emergency room is not eligible for sharing. Trinity HealthShare must be notified of all ER visits within 48 hours. Medical records will be reviewed for all ER visits to determine eligibility. An emergency is defined as treatment that must be rendered to the patient immediately for the alleviation of the sudden onset of an unforeseen illness or injury that, if not treated, would lead to further disability or death. Examples of an emergency include, but are not limited to, severe pain, choking, major bleeding, heart attack, or a sudden, unexplained loss of consciousness.

Eligibility for Cancer Needs. In order for needs related to cancer hospitalization of any type to be eligible (e.g. breast, colorectal, leukemia, lymphoma, prostate, skin, etc.), the member must meet the following requirements:

The member is required to contact Trinity HealthShare within 30 days of diagnosis. If the member fails to notify Trinity HealthShare within the 30-day time frame, the member will be responsible for 50% of the total allowed charges after the MRSA(s) has been assessed to the member for in-patient cancer hospitalization.

Early detection provides the best chance for successful treatment and in the most cost effective manner. Effective January 1, 2017, the membership requires that all members aged 40 and older receive appropriate screening tests every other year – mammogram or thermography and pap smear with pelvic exams for women and PSA testing for men. ***Failure to obtain biannual mammograms and gynecological tests listed above for women or PSA tests for men will render future needs for breast, cervical, endometrial, ovarian, or prostate cancer ineligible for sharing.***

DISPUTE RESOLUTION AND APPEAL

Trinity HealthShare is a voluntary association of like-minded people who come together to assist each other by sharing medical expenses. Such a sharing and caring association does not lend itself well to the mentality of legally enforceable rights. However, it is recognized that differences of opinion will occur, and that a methodology for resolving disputes must be available. Therefore, by becoming a Sharing Member of Trinity HealthShare, you agree that any dispute you have with or against Trinity HealthShare, its associates, or employees will be settled using the following steps of action, and only as a course of last resort.

If a determination is made with which the sharing member disagrees and believes there is a logically defensible reason why the initial determination is wrong, then the sharing member may file an appeal.

A. **1st Level Appeal.** Most differences of opinion can be resolved simply by calling Trinity HealthShare who will try to resolve the matter telephonically within a reasonable amount of time.

B. **2nd Level Appeal.** If the sharing member is unsatisfied with the determination of the member services representative, then the sharing member may request a review by the Internal Resolution Committee, made up of three Trinity HealthShare officials. The appeal must be in writing, stating the elements of the dispute and the relevant facts. Importantly, the appeal should address all of the following:

1. What information does Trinity HealthShare have that is either incomplete or incorrect?
2. How do you believe Trinity HealthShare has misinterpreted the information already on hand?
3. Which provision in the Trinity HealthShare Guidelines do you believe Trinity HealthShare applied incorrectly?

Within thirty (30) days, the Internal Resolution Committee will render a written decision, unless additional medical documentation is required to make an accurate decision.

C. **3rd Level Appeal.** Should the matter remain unresolved, then the aggrieved party may ask that the dispute be submitted to three sharing members in good standing and randomly chosen by Trinity HealthShare, who shall agree to review the matter and shall constitute an External Resolution Committee. Within thirty (30) days the External Resolution Committee shall render their opinion in writing, unless additional medical documentation is required to make an accurate decision.

D. **Final Appeal.** If the aggrieved sharing member disagrees with the conclusion of his/her fellow sharing members, then the aggrieved party may ask that the dispute be submitted to a medical expense auditor, who shall have the matter reviewed by a panel consisting of personnel who were not involved in the original determination and who shall render their opinion in writing within thirty (30) days, unless additional medical documentation is required to make an accurate decision.

E. **Mediation and Arbitration.** If the aggrieved sharing member disagrees with the conclusion of the Final Appeal Panel, then the matter shall be resolved by first submitting the disputed matter to mediation. If the dispute is not resolved the matter will be submitted to legally binding arbitration in accordance with the Rules and Procedure of the American Arbitration Association. Sharing members agree and understand that these methods shall be the sole remedy to resolve any controversy or claim arising out of the Sharing Guidelines, and expressly waive their right to file a lawsuit in any civil court against one another for such disputes; except to enforce an arbitration decision. Any arbitration shall be held in Atlanta, Georgia, and conducted in the English language subject to the laws of the State of Georgia. Trinity HealthShare shall pay the filing fees for the arbitration and arbitrator in full at the time of filing. All other expenses of the arbitration shall be paid by each party including costs related to transportation, accommodations, experts, evidence gathering, and legal counsel. Further agreed that the aggrieved sharing member shall reimburse the full costs associated with the arbitration, should the arbitrator render a judgment in favor of Trinity HealthShare and not the aggrieved sharing member.

   The aggrieved sharing member agrees to be legally bound by the arbitrator's final decision. The parties may alternatively elect to use other professional arbitration services available in the Atlanta metropolitan area, by mutual agreement.

APPENDIX A: PLAN DETAILS BRONZE

Lifetime Maximum Sharing: $1,000,000

Bronze Program cost-sharing parameters for pre-existing conditions. Hospitalization, In-Patient and Out-Patient Surgery, Specialty Care, and Emergency Room services for pre-existing conditions have a 24 month waiting period.

A. Pre-existing Condition: chronic or recurrent conditions that have evidenced signs/symptoms and/or received treatment and/or medication within the past 24 months are not eligible for sharing during the first 24 months of membership.

B. Upon the 25th month of continuous membership and thereafter, the condition will no longer be subject to the pre-existing condition sharing limitations.

C. Appeals may be considered for earlier sharing in surgical interventions when it is in the best interest of both the members and the membership to do so.

Cancer sharing is available immediately. Cancer sharing is only available for non-recurrent cancer diagnosis.

1. ER visits are subject to review, and are meant only for life threatening situations.

2. Non-emergency surgical services are unavailable for the first 2 months for Bronze. Surgical services do not include cosmetic surgery.

3. All members seeking cost-sharing must use the prescription services Rx Valet included with your plan. Prescription drugs are eligible for cost-sharing by the percentage shown once a separate MSRA of $1,500 for all prescriptions is met. Members are required to pay prescription cost out-of-pocket before submitting receipts to Trinity HealthShare mailing address, Attn. Trinity Rx Claims, for review and cost-sharing. Maximum reimbursement of $4,000 per plan year.

Trinity HealthShare plans follow medical eligibility review protocols described in the plan but are not a promise to pay. Sharing is available for all eligible medical needs.

Administrative and Conditional Fees: $125 one-time application fee per enrollment. Products NOT available in: AK, HI, MD, ME, PR, WA, WY; subject to change w/o prior notice.

APPENDIX A: PLAN DETAILS BRONZE LEVEL

PPO Network	PPO Multiplan PHCS	
Eligible Medical Cost-Sharing	Network	Non-Network
Eligible prior to meeting Member Shared Responsibility Amount (MSRA)		
Wellness & Preventive Care	100%	50% after MSRA
Telemedicine	Unlimited	Unlimited
Primary Care	$50 Consult Fee	50% after MSRA
Specialty Care	$125 Consult Fee	50% after MSRA
Urgent Care	$100 Consult Fee	50% after MSRA
Emergency Room Services[1] Emergency room services including hospital facility and physician charges.	$500 Consult Fee	$500 Consult Fee
Eligible after meeting Member Shared Responsibility Amount (MSRA)[2]		
MSRA Per member 1 (1–2 members)	$1,000, $2,500, $5,000, $10,000	50% towards MSRA
MSRA Family maximum (3+ members)	$3,000, $7,500, $15,000, $30,000	50% towards MSRA
Out-of-Pocket Maximum Per member 1 (1–2 members)	$3,000, $7,500, $15,000, $30,000	$6,000, $15,000, $30,000, $60,000
Out-of-Pocket Maximum Family maximum (3+ members)	$9,000, $22,500, $45,000, $90,000	$18,000, $45,000, $90,000, $180,000
Co-expense (Plan Pays)	60% after MSRA	50% after MSRA
Hospitalization In-Patient	60% after MSRA	50% after MSRA
Hospitalization Out-Patient	60% after MSRA	50% after MSRA
Imaging Eligible charges for CT, PET scans, MRIs, and the charges for related supplies.	60% after MSRA	50% after MSRA
Laboratory Out-Patient and Professional Services Sharing eligible for professional components of labs, including office, out-patient, and in-patient charges.	60% after MSRA	50% after MSRA
X-rays and Diagnostic Imaging Sharing eligible for the professional components of labs, including the office, out-patient, and in-patient charges.	60% after MSRA	50% after MSRA
Generic Prescription Drugs	No Cost-Sharing	Not eligible
Preferred Brand Drugs	50% Cost-Sharing[3]	Not eligible
Non-Preferred Brand Drugs	No Cost-Sharing	Not eligible
Mail-Order	75% Cost-Sharing[3]	Not eligible

See Legal Appendix on page 36

APPENDIX B: PLAN DETAILS SILVER

Lifetime Maximum Sharing: $1,000,000

Silver Program cost-sharing parameters for pre-existing conditions. Hospitalization, In-Patient and Out-Patient Surgery, Specialty Care, and Emergency Room services for pre-existing conditions have limitations during the first 24 months of membership.

A. During the first two years (24 months) of continuous membership, sharing is available up to $10,000 of total medical expenses incurred for pre-existing conditions per year, after a separate MSRA equal to two times your plan MSRA.

B. Upon inception of the 25th month of continuous membership and thereafter, the condition may no longer be subject to the pre-existing condition sharing limitations.

C. Appeals may be considered for earlier sharing in surgical interventions when it is in the mutual best interest of both the members and the membership to do so.

Cancer sharing is available immediately. Cancer sharing is only available for non-recurrent cancer diagnosis.

1. ER visits are subject to review, and are meant only for life threatening situations.

2. Non-emergency surgical services are unavailable for the first 2 months for Silver. Surgical services do not include cosmetic surgery.

3. All members seeking cost-sharing must use the prescription services Rx Valet included with your plan. Prescription drugs are eligible for cost-sharing by the percentage shown once a separate MSRA of $1,500 for all prescriptions is met. Members are required to pay prescription cost out-of-pocket before submitting receipts to Trinity HealthShare mailing address, Attn. Trinity Rx Claims, for review and cost-sharing. Maximum reimbursement of $4,000 per plan year.

Trinity HealthShare plans follow medical eligibility review protocols described in the plan but are not a promise to pay. Sharing is available for all eligible medical needs.

Administrative and Conditional Fees: $125 one-time application fee per enrollment. Products NOT available in: AK, HI, MD, ME, PR, WA, WY; subject to change w/o prior notice.

APPENDIX B: PLAN DETAILS SILVER LEVEL

PPO Network	PPO Multiplan PHCS	
Eligible Medical Cost-Sharing	Network	Non-Network
Eligible prior to meeting Member Shared Responsibility Amount (MSRA)		
Wellness & Preventive Care	100%	60% after MSRA
Telemedicine	Unlimited	Unlimited
Primary Care	$35 Consult Fee	60% after MSRA
Specialty Care	$75 Consult Fee	60% after MSRA
Urgent Care	$75 Consult Fee	60% after MSRA
Emergency Room Services[1] Emergency room services including hospital facility and physician charges.	$300 Consult Fee	$500 Consult Fee
Eligible after meeting Member Shared Responsibility Amount (MSRA)[2]		
MSRA Per member 1 (1–2 members)	$1,000, $2,500, $5,000, $10,000	60% towards MSRA
MSRA Family maximum (3+ members)	$3,000, $7,500, $15,000, $30,000	60% towards MSRA
Out-of-Pocket Maximum Per member 1 (1–2 members)	$3,000, $7,500, $15,000, $30,000	$6,000, $15,000, $30,000, $60,000
Out-of-Pocket Maximum Family maximum (3+ members)	$9,000, $22,500, $45,000, $90,000	$18,000, $45,000, $90,000, $180,000
Co-expense (Plan Pays)	70% after MSRA	60% after MSRA
Hospitalization In-Patient	70% after MSRA	60% after MSRA
Hospitalization Out-Patient	70% after MSRA	60% after MSRA
Imaging Eligible charges for CT, PET scans, MRIs, and the charges for related supplies.	70% after MSRA	60% after MSRA
Laboratory Out-Patient and Professional Services Sharing eligible for professional components of labs, including office, out-patient, and in-patient charges.	70% after MSRA	60% after MSRA
X-rays and Diagnostic Imaging Sharing eligible for the professional components of labs, including the office, out-patient, and in-patient charges.	70% after MSRA	60% after MSRA
Generic Prescription Drugs	No Cost-Sharing	Not eligible
Preferred Brand Drugs	50% Cost-Sharing[3]	Not eligible
Non-Preferred Brand Drugs	No Cost-Sharing	Not eligible
Mail-Order	75% Cost-Sharing[3]	Not eligible

See Legal Appendix on page 38

APPENDIX C: PLAN DETAILS GOLD

Lifetime Maximum Sharing: $1,000,000

Gold Program cost-sharing parameters for pre-existing conditions. Hospitalization, In-Patient and Out-Patient Surgery, Specialty Care, and Emergency Room services for pre-existing conditions have limitations during the first 24 months of membership.

A. During the first two years (24 months) of continuous membership, sharing is available up to $20,000 of total medical expenses incurred for pre-existing conditions per year, after a separate MSRA equal to two times your plan MSRA.

B. Upon inception of the 25th month of continuous membership and thereafter, the condition may no longer be subject to the pre-existing condition sharing limitations.

C. Appeals may be considered for earlier sharing in surgical interventions when it is in the mutual best interest of both the members and the membership to do so.

Cancer sharing is available immediately. Cancer sharing is only available for non-recurrent cancer diagnosis.

1. ER visits are subject to review, and are meant only for life threatening situations.

2. Non-emergency surgical services are unavailable for the first 2 months for Gold. Surgical services do not include cosmetic surgery.

3. All members seeking cost-sharing must use the prescription services Rx Valet included with your plan. Prescription drugs are eligible for cost-sharing by the percentage shown once a separate MSRA of $1,500 for all prescriptions is met. Members are required to pay prescription cost out-of-pocket before submitting receipts to Trinity HealthShare mailing address, Attn. Trinity Rx Claims, for review and cost-sharing. Maximum reimbursement of $4,000 per plan year.

Trinity HealthShare plans follow medical eligibility review protocols described in the plan but are not a promise to pay. Sharing is available for all eligible medical needs.

Administrative and Conditional Fees: $125 one-time application fee per enrollment. Products NOT available in: AK, HI, MD, ME, PR, WA, WY; subject to change w/o prior notice.

APPENDIX C: PLAN DETAILS GOLD LEVEL

PPO Network	PPO Multiplan PHCS	
Eligible Medical Cost-Sharing	Network	Non-Network
Eligible prior to meeting Member Shared Responsibility Amount (MSRA)		
Wellness & Preventive Care	100%	70% after MSRA
Telemedicine	Unlimited	Unlimited
Primary Care	$20 Consult Fee	70% after MSRA
Specialty Care	$75 Consult Fee	70% after MSRA
Urgent Care	$75 Consult Fee	70% after MSRA
Emergency Room Services[1] Emergency room services including hospital facility and physician charges.	$150 Consult Fee	$300 Consult Fee
Eligible after meeting Member Shared Responsibility Amount (MSRA)[2]		
MSRA Per member 1 (1–2 members)	$1,000, $2,500, $5,000, $10,000	70% towards MSRA
MSRA Family maximum (3+ members)	$3,000, $7,500, $15,000, $30,000	70% towards MSRA
Out-of-Pocket Maximum Per member 1 (1–2 members)	$3,000, $7,500, $15,000, $30,000	$6,000, $15,000, $30,000, $60,000
Out-of-Pocket Maximum Family maximum (3+ members)	$9,000, $22,500, $45,000, $90,000	$18,000, $45,000, $90,000, $180,000
Co-expense (Plan Pays)	80% after MSRA	70% after MSRA
Hospitalization In-Patient	80% after MSRA	70% after MSRA
Hospitalization Out-Patient	80% after MSRA	70% after MSRA
Imaging Eligible charges for CT, PET scans, MRIs, and the charges for related supplies.	80% after MSRA	70% after MSRA
Laboratory Out-Patient and Professional Services Sharing eligible for professional components of labs, including office, out-patient, and in-patient charges.	80% after MSRA	70% after MSRA
X-rays and Diagnostic Imaging Sharing eligible for the professional components of labs, including the office, out-patient, and in-patient charges.	80% after MSRA	70% after MSRA
Generic Prescription Drugs	No Cost-Sharing	Not eligible
Preferred Brand Drugs	50% Cost-Sharing[3]	Not eligible
Non-Preferred Brand Drugs	No Cost-Sharing	Not eligible
Mail-Order	75% Cost-Sharing[3]	Not eligible

See Legal Appendix on page 40

APPENDIX D: TERMS, CONDITIONS, & SPECIAL CONSIDERATIONS

1. The Welcome Kit you received electronically includes this Member Guide, your Membership Card(s), a Welcome Letter, and important information to activate your membership.

2. Keep your Membership Card with you at all times to present to a provider to confirm eligibility.

3. The ACA is subject to change at any time; Aliera reserves the right to adhere to those changes without notice to the Member.

4. Activate your Plan Membership by following the instructions in this Member Guide.

5. Set up your telemedicine account by following the instructions on the Welcome Letter. Within three weeks of enrollment in Aliera's telemedicine partnering company, Members receive ID Card(s) for the telemedicine service along with instructions on how to utilize the service.

6. Telemedicine operates subject to state regulations and may not be available in certain states.

7. Telemedicine phone consultations are available 24/7/365, with face-to-face internet consultations available between the hours of 7 a.m. and 9 p.m., Monday – Friday.

8. Telemedicine does not guarantee that a prescription will be written.

9. Telemedicine does not prescribe DEA-controlled substances, non-therapeutic drugs, and certain other drugs which may be harmful because of their potential for abuse. Telemedicine doctors reserve the right to deny care for potential misuse of services.

10. Durable Medical Equipment (DME) – i.e. crutches, etc. – is not included in your Plan. Members will be charged for DME at time of service.

11. Aliera cannot guarantee that a provider will accept an Aliera Plan if the Member fails to contact the Aliera Concierge Service first.

12. Member Care Specialists are available to assist you, Monday through Friday, 8 a.m. to 8 p.m. ET at (844) 834-3456. If you call after hours, follow the prompts.

13. Plans may vary from state to state. Providers may be added or removed from Aliera's network at any time without notice.

14. Not all geographical areas are serviced by Aliera Healthcare. Should a Member visit an emergency room because urgent care facilities are unavailable in the Member's area, Aliera offers a one-time, once-a-year, $105 credit (ex gratia) to the Member to help offset the costs incurred.

15. Aliera telemedicine partners do not replace the Primary Care Provider.

16. Primary Care is defined as "episodic primary care" or "sick care." Members are responsible for paying a consult fee at the time of service; no consult fee is due for preventive service.

17. Most network facilities are able to accommodate both urgent care and primary care needs.

18. Not all PPO providers accept an AlieraCare plan. While Aliera offers one of the largest PPO networks in the country, some providers may not participate.

DISCLOSURES

1. Aliera Healthcare, the Aliera Healthcare logo, and other plan or service logos are trademarks of Aliera Healthcare, Inc. and may not be used without written permission.

2. Aliera and Trinity programs are NOT insurance. Aliera Healthcare, Inc./ Trinity HealthShare does not guarantee the quality of services or products offered by individual providers. Members may change providers upon 30 days' notice if not satisfied with the medical services provided.

3. Aliera's Healthcare Plans offer services only to Members and dependents on your Plan.

4. Aliera reserves the right to interpret the terms of this membership to determine the level of medical services received hereunder.

5. This membership is issued in consideration of the Member's application and the Member's payment of a monthly fee as provided under these Plans. Omissions and misstatements, or incorrect, incomplete, fraudulent, or intentional misrepresentation to the assumed risk in your application may void your membership, and services may be denied.

ABBREVIATIONS

ACA	Affordable Care Act (Obamacare)
CMS	Centers for Medicare and Medicaid Services
DEA	Drug Enforcement Administration
DME	Durable Medical Equipment
DPCMH	Direct Primary Care Medical Home Plans
HCSM	Health Care Sharing Ministry
MEC	Minimum Essential Coverage
PCP	Primary Care Provider
PPO	Participating Provider Organization
UC	Urgent Care

APPENDIX E: LEGAL NOTICES

The following legal notices are the result of discussions by Trinity HealthShare or other healthcare sharing ministries with several state regulators and are part of an effort to ensure that Sharing Members understand that Trinity HealthShare is not an insurance company and that it does not guarantee payment of medical costs. Our role is to enable self-pay patients to help fellow Aliera members through voluntary financial gifts.

GENERAL LEGAL NOTICE

This program is not an insurance company nor is it offered through an insurance company. This program does not guarantee or promise that your medical bills will be paid or assigned to others for payment. Whether anyone chooses to pay your medical bills will be totally voluntary. As such, this program should never be considered as a substitute for an insurance policy. Whether you receive any payments for medical expenses and whether or not this program continues to operate, you are always liable for any unpaid bills.

STATE SPECIFIC NOTICES

Alabama Code Title 22-6A-2

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Arizona Statute 20-122

Notice: the organization facilitating the sharing of medical expenses is not an insurance company and the ministry's guidelines and plan of operation are not an insurance policy. Whether anyone chooses to assist you with your medical bills will be completely voluntary because participants are not compelled by law to contribute toward your medical bills. Therefore, participation in the ministry or a subscription to any of its documents should not be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this ministry continues to operate, you are always personally responsible for the payment of your own medical bills.

Arkansas Code 23-60-104.2

Notice: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor plan of operation is an insurance policy. If anyone chooses to assist you with your medical bills, it will be totally voluntary because participants are not compelled by law to contribute toward your medical bills. Participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive a payment for medical expenses or if this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Florida Statute 624.1265

Trinity HealthShare is not an insurance company, and membership is not offered through an insurance company. Trinity HealthShare is not subject to the regulatory requirements or consumer protections of the Florida Insurance Code.

Georgia Statute 33-1-20

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Idaho Statute 41-121

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Illinois Statute 215-5/4-Class 1-b

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation constitute or create an insurance policy. Any assistance you receive with your medical bills will be totally voluntary. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Whether or not you receive any payments for medical expenses and whether or not this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Indiana Code 27-1-2.1

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor its plan of operation is an insurance policy. Any assistance you receive with your medical bills will be totally voluntary. Neither the organization nor any other participant can be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Whether or not you receive any payments for medical expenses and whether or not this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Kentucky Revised Statute 304.1-120 (7)

Notice: Under Kentucky law, the religious organization facilitating the sharing of medical expenses is not an insurance company, and its guidelines, plan of operation, or any other document of the religious organization do not constitute or create an insurance policy. Participation in the religious organization or a subscription to any of its documents shall not be considered insurance. Any assistance you receive with your medical bills will be totally voluntary. Neither the organization nor any participant shall be compelled by law to contribute toward your medical bills. Whether or not you receive any payments for medical expenses, and whether or not this organization continues to operate, you shall be personally responsible for the payment of your medical bills.

Louisiana Revised Statute Title 22-318,319

Notice: The ministry facilitating the sharing of medical expenses is not an insurance company. Neither the guidelines nor the plan of operation of the ministry constitutes an insurance policy. Financial assistance for the payment of medical expenses is strictly voluntary. Participation in the ministry or a subscription to any publication issued by the ministry shall not be considered as enrollment in any health insurance plan or as a waiver of your responsibility to pay your medical expenses.

Maine Revised Statute Title 24-A, §704, sub-§3

Notice: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. Participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Maryland Article 48, Section 1-202(4)

Notice: This publication is not issued by an insurance company nor is it offered through an insurance company. It does not guarantee or promise that your medical bills will be published or assigned to others for payment. No other subscriber will be compelled to contribute toward the cost of your medical bills. Therefore, this publication should never be considered a substitute for an insurance policy. This activity is not regulated by the State Insurance Administration, and your liabilities are not covered by the Life and Health Guaranty Fund. Whether or not you receive any payments for medical expenses and whether or not this entity continues to operate, you are always liable for any unpaid bills.

Mississippi Title 83-77-1

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment of medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Missouri Section 376.1750

Notice: This publication is not an insurance company nor is it offered through an insurance company. Whether anyone chooses to assist you with your medical bills will be totally voluntary, as no other subscriber or member will be compelled to contribute toward your medical bills. As such, this publication should never be considered to be insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always personally responsible for the payment of your own medical bills.

Nebraska Revised Statute Chapter 44-311

IMPORTANT NOTICE. This organization is not an insurance company, and its product should never be considered insurance. If you join this organization instead of purchasing health insurance, you will be considered uninsured. By the terms of this agreement, whether anyone chooses to assist you with your medical bills as a participant of this organization will be totally voluntary, and neither the organization nor any participant can be compelled by law to contribute toward your medical bills. Regardless of whether you receive payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills. This organization is not regulated by the Nebraska Department of Insurance. You should review this organization's guidelines carefully to be sure you understand any limitations that may affect your personal medical and financial needs.

New Hampshire Section 126-V:1

IMPORTANT NOTICE: This organization is not an insurance company, and its product should never be considered insurance. If you join this organization instead of purchasing health insurance, you will be considered uninsured. By the terms of this agreement, whether anyone chooses to assist you with your medical bills as a participant of this organization will be totally voluntary, and neither the organization nor any participant can be compelled by law to contribute toward your medical bills. Regardless of whether you receive payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills. This organization is not regulated by the New Hampshire Insurance Department. You should review this organization's guidelines carefully to be sure you understand any limitations that may affect your personal medical and financial needs.

North Carolina Statute 58-49-12

Notice: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor its plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be voluntary. No other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally liable for the payment of your own medical bills.

Pennsylvania 40 Penn. Statute Section 23(b)

Notice: This publication is not an insurance company nor is it offered through an insurance company. This publication does not guarantee or promise that your medical bills will be published or assigned to others for payment. Whether anyone chooses to pay your medical bills will be totally voluntary. As such, this publication should never be considered a substitute for insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always liable for any unpaid bills.

South Dakota Statute Title 58-1-3.3

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payments for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Texas Code Title 8, K, 1681.001

Notice: This health care sharing ministry facilitates the sharing of medical expenses and is not an insurance company, and neither its guidelines nor its plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the ministry or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this ministry continues to operate, you are always personally responsible for the payment of your own medical bills. Complaints concerning this health care sharing ministry may be reported to the office of the Texas attorney general.

The ministry will assign a recommended cost sharing amount to the membership each month (“Monthly Share Amount”). By submitting the Monthly Share Amount, you instruct the ministry to assign your contribution as prescribed by the Guidelines. Up to 40% of your member contribution goes towards the administration of this plan. Administration costs are not all inclusive of vendor costs, which could account for up to 32% of the member contribution (monthly recommended share amount). Contributions to the member “Share Box” will never be less than 28% of the member monthly recommended share amount.

Virginia Code 38.2-6300-6301

Notice: This publication is not insurance, and is not offered through an insurance company. Whether anyone chooses to assist you with your medical bills will be totally voluntary, as no other member will be compelled by law to contribute toward your medical bills. As such, this publication should never be considered to be insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always personally responsible for the payment of your own medical bills

Wisconsin Statute 600.01 (1) (b) (9)

ATTENTION: This publication is not issued by an insurance company, nor is it offered through an insurance company. This publication does not guarantee or promise that your medical bills will be published or assigned to others for payment. Whether anyone chooses to pay your medical bills is entirely voluntary. This publication should never be considered a substitute for an insurance policy. Whether or not you receive any payments for medical expenses, and whether or not this publication continues to operate, you are responsible for the payment of your own medical bills.

This is NOT Insurance.

NOTES:

AlieraCare™
BRONZE | SILVER | GOLD

Trinity HealthShare℠

PO Box 28220 Atlanta, GA 30358
Toll Free 844-834-3456
AlieraHealthcare.com

AlieraCare Plans Are NOT Insurance.

AlieraCare_BSG_MemberGuide_041819_FINv1

KROMODIMEDJO DECLARATION

EXHIBIT 6

Member Information

Name: Michael Selimo
Address: [redacted] Boonton, NJ 07005-8710
Phone: (973) [redacted]
Email: [redacted]@gmail.com
Date of Birth: [redacted]
Gender: M

Dependent Information

Name	Relationship	Date of Birth	Gender	SSN
Kristin Selimo	Spouse	[redacted]	F	[redacted]
[redacted]	Child	[redacted]	F	[redacted]
[redacted]	Child	[redacted]	M	[redacted]

Product Information

Trinity HealthShare Premium

Costs for Hospitalization, Emergency Room, In-Patient, and Out-Patient procedures are shared once the Member Shared Responsibility Amount has been met. The Per Incident limit is $500,000 sharing amount, capped at $1,000,000 lifetime sharing amount.

$267.31 per Month for Family

Questions

MSRA

5000

At the core of what the Healthcare Sharing Ministry does, and how they relate to and engage with one another as a community of people, is a set of common beliefs.

Yes

You understand that this sharing plan has a 24-month waiting period for pre-existing conditions, where pre-existing conditions are defined as conditions that exist at the time of enrollment that have evidenced symptoms, received treatment, and/or medication within the past 24 months.

Yes

You understand that other medical services and emergency surgical services are eligible for cost sharing immediately, but elective surgical services require a 60-day wait period (180-day for AlieraCare Value and Plus) following your effective date.

Yes

You understand that Aliera Companies, and Trinity HealthShare, Inc. have the authority, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to request your medical records to facilitate the payment of medical expenses.

Yes

Check any of these health conditions you have:

Do you use tobacco in any form?

Do you have or ever had Cancer?

If you had Cancer, how long ago?

Do you play in any competitive sports?

Do you drink alcohol?

If you drink Alcohol, what is your weekly intake?

Is anyone applying pregnant?

AlieraCare Premium

Trinity HealthShare's AlieraCare Value | Plus | Premium program is a three-tiered program of alternative healthcare levels with robust healthcare sharing services for 30% to 60% less than more traditional medical plans.

$496.44 per Month for Family

Questions

MSRA

5000

At the core of what the Healthcare Sharing Ministry does, and how they relate to and engage with one another as a community of people, is a set of common beliefs.

Yes

You understand that this sharing plan has a 24-month waiting period for pre-existing conditions, where pre-existing conditions are defined as conditions that exist at the time of enrollment that have evidenced symptoms, received treatment, and/or medication within the past 24 months.

Yes

You understand that other medical services and emergency surgical services are eligible for cost sharing immediately, but elective surgical services require a 60-day wait period (180-day for AlieraCare Value and Plus) following your effective date.

Yes

You understand that Aliera Companies, and Trinity HealthShare, Inc. have the authority, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to request your medical records to facilitate the payment of medical expenses.

Yes

Check any of these health conditions you have:

Do you use tobacco in any form?

Do you have or ever had Cancer?

If you had Cancer, how long ago?

Do you play in any competitive sports?

Do you drink alcohol?

If you drink Alcohol, what is your weekly intake?

Is anyone applying pregnant?

Terms and Conditions for AlieraCare Premium

Trinity Healthshare Program Disclosures

This is not a contract. This is a voluntary program offered by Ensurian, in relationship with a HealthCare Sharing Ministry (HCSM) program offered within certain programs. Your membership is with Trinity and cannot be transferred to anyone else. Only you and your enrolled dependents are eligible under the membership.

All Trinity members utilizing any Health Care Sharing Ministry services are required to declare their acknowledgment of the Statement of Beliefs and make an attestation that they are of like mind with the ministry beliefs.

Statement of Beliefs

1. We believe that our personal rights and liberties originate from God and are bestowed on us by God.
2. We believe every individual has a fundamental religious right to worship God in his or her own way.
3. We believe it is our moral and ethical obligation to assist our fellow man when he/she is in need according to our available resources and opportunity.
4. We believe it is our spiritual duty to God and our ethical duty to others to maintain a healthy lifestyle and avoid foods, behaviors or habits that produce sickness or disease to ourselves or others.
5. We believe it is our fundamental right of conscience to direct our own healthcare, in consultation with physicians, family or other valued advisors.

DISCLAIMER

THE MINISTRY IS NOT AN INSURANCE COMPANY AND THE MINISTRY DOES NOT OFFER ANY INSURANCE PRODUCTS OR POLICIES. THE MINISTRY DOES NOT ASSUME ANY RISK FOR YOUR MEDICAL EXPENSES, AND THE MINISTRY MAKES NO PROMISE TO PAY. HEALTH CARE SHARING MINISTRIES ARE NOT GOVERNED BY INSURANCE LAWS. THE HEALTH CARE SHARING MINISTRY OFFERS VOLUNTARY PARTICIPATION IN ITS HEALTH CARE SHARING MINISTRY. MINISTRY SERVICES ARE ADMINISTERED BY ALIERA COMPANIES.

This is not Insurance

A Health Care Sharing Ministry (“HCSM”) is a group of individuals that share a common set of ethical or religious beliefs and share their medical expenses in accordance with those beliefs without regard to the state in which a member resides or is employed. Services are based on a religious tradition of mutual aid, neighborly assistance, and burden sharing. The ministry does not subsidize self-destructive behaviors and lifestyles but is specifically tailored for individuals who maintain a healthy lifestyle, make responsible choices regarding health and care, and believe in helping others. A Health Care Sharing Ministry program is **NOT** health insurance.

Tax Exemption

YOU SHOULD CONSULT WITH A TAX PROFESSIONAL FOR DETAILS REGARDING YOUR EXEMPTION.

Health Care Sharing Disclosures

Promise to Pay

The ministry does not make a promise to pay or any guarantee of payment of your medical expenses. You will be responsible for the payment of your medical bills. The ministry does not assume your risk. The ministry does not guarantee that your medical expenses will be shared by other members participating in a Trinity Program that utilize health care sharing services.

Voluntary

Participation in the ministry HCSM is voluntary. Enrollment as a Trinity member and participant of the ministry HCSM is voluntary and the sharing of monetary contributions are also voluntary. Enrollment in the ministry sharing program is not a contract. You are free to cancel your participation at any time. The ministry requests a Monthly Share Amount, to be collected each month you are enrolled, to facilitate the payment of sharing requests published on behalf of other participants.

Guidelines

The ministry manages its sharing contributions by establishing guidelines that define eligible sharing (“Guidelines”). The Guidelines are not a contract of insurance. They do not constitute an agreement, a promise to pay, or an obligation to share. The Guidelines are intended to ensure that every participant has paid their own medical expenses, as they are financially able, before requesting others to share with you to assist in paying remaining medical expenses. The Guidelines specify what type of expenses are eligible for sharing requests, so all participants of the ministry HCSM can expect a reasonable and equitable level of sharing requests to be published monthly.

The ministry is authorized to exclude sharing for pre-existing conditions. You are required to fully disclose pre-existing conditions as part of your participation in the HCSM. The ministry reserves the right to exclude sharing eligibility for any pre-existing conditions, whether disclosed at the time of your enrollment or discovered after the effective date of the membership.

AlieraCare

- Pre-existing conditions have a 24-month waiting period.
- Cancer diagnoses after enrollment have a 12-month continuous membership requirement before sharing is eligible. This means that if you are diagnosed with cancer after you become a member, you are not eligible to request cost sharing of your expenses until you have been a Trinity member for 12 consecutive months.
- There is a maximum limit of $1 million on this Program.

CarePlus

- Cost sharing does not apply (not eligible) to any illness or accident for which a person has been diagnosed, received medical treatment, been examined, taken medication, or had symptoms within the 24-month period prior to the application date.
- Events covered during the first year of membership become pre-existing condition for the second year, resetting after 24 months.

InterimCare

- Pre-existing conditions have a 24-month waiting period.
- Cancer coverage is provided immediately if a pre-existing cancer condition did not exist within 5 years prior to or at the time of application.
- Charges resulting directly from a pre-existing condition are excluded from cost sharing.
- The pre-existing condition exclusions for InterimCare programs will apply for all members, including those under the age of 19.
- There is a maximum limit of $1 million on this Program.

TrinityCare

- Pre-existing conditions have a 24-month waiting period.
- Cancer diagnoses after enrollment have a 12-month continuous membership requirement before sharing is eligible. This means that if you are diagnosed with cancer after you become a member, you are not eligible to request cost sharing of your expenses until you have been a Trinity member for 12 consecutive months.
- There is a maximum limit of $1 million on this Program.

Dates of Service

The ministry reserves the right to make updates to its Guidelines at any time. The Guidelines in effect at the time of service will supersede all previous versions of the Guidelines. Members will be notified in advance of updates.

Membership Dues and Fees

- An administrative fee of $25.00 is assigned to administrative costs from each Monthly Share Amount regardless of family size, as provided in the Guidelines. Collection of this fee will begin in the third membership month and will be collected monthly for each following month.

Assigned Need

The ministry will assign a recommended cost sharing amount to the membership each month (“Monthly Share Amount”). By submitting the Monthly Share Amount, you instruct the ministry to assign your contribution as prescribed by the Guidelines.
Up to 40% of your member contribution goes towards the administration of this program and other general overhead costs to successfully carry out the duties of administering these services.

Membership Guidelines Details

Each Trinity member is responsible for reviewing the HCSM Guidelines provided at the time of enrollment, and to abide by the terms of the Guidelines. It is your responsibility to understand which of your medical expenses are eligible for cost sharing, and which medical expenses are NOT eligible for cost sharing. Members are also provided with a toll-free number to contact Member Services with any questions they have. It is recommended that members call Member Services with any questions regarding eligibility prior to seeking medical services.

Authorizations

- I authorize Aliera Companies, on behalf of the ministry, to collect the Monthly Share Amount as a recurring monthly transaction.
- I authorize my first Monthly Share Amount to be processed immediately upon completion of my enrollment.
- I understand that the enrollment fee will be refunded automatically if all individuals on my enrollment form fail to attest to the ministry Statement of Beliefs or if I withdraw my enrollment prior to my membership effective date.
- I understand that the enrollment fee will not be refunded if, in the course of enrolling, I fail to respond to written or verbal inquiries from the ministry or Aliera Companies (as the ministry’s administrator) for more than sixty days.
- I understand that the ministry offers voluntary participation in the health care sharing ministry, and I understand that Aliera Companies owns and administers memberships on behalf of the ministry.
- I understand both Aliera Companies and the HCSM have the authorization to contact providers to request the release of medical records on behalf of the member.

Acknowledgment

- I affirm that the name and personal information provided on this form are true and correct.
- I affirm that I understand and accept the disclosures presented above.

Refunds

You are entitled to a full refund, including the one-time enrollment fee, if you cancel your membership within 10 days of the effective date of the membership. You must cancel within 10 days of your effective date to be eligible for a full refund.
If you are canceling your membership after the first 30 days of your membership, you may be eligible for a refund of the most recently paid membership period, but only if you cancel within 10 days of your scheduled billing date. Any cancellation requests processed more than 10 days from the scheduled billing date will NOT receive a refund, and the membership will remain active until the end of that billing period.
Refunds will be processed as a credit to the same card or account provided for billing. Requests involving refunds payable by check may be delayed up to 30 business days.

Payment Method

Type: Credit Card
Name: Michael Selimo
Number:
Expiration:

Electronic Signature

By electronically acknowledging this authorization, I acknowledge that I have read and agree to the terms and conditions set forth in this agreement.

Signed as Parent / Guardian
Name: Michael selimo
Date: October 25, 2019 at 6:47:43 PM
IP Address:
System:

KROMODIMEDJO DECLARATION

EXHIBIT 7

ALIERACARE™

Your Aliera Family of Unity HealthShare
Cost Sharing Plans

MEMBER GUIDE & SHARING NEEDS

In partnership with

ALIERA™ Healthcare

UNITY™ HEALTHSHARE

Contents

MEMBER GUIDE

WELCOME!

Welcome to your AlieraCare plan! Thank you for becoming a Unity HealthShare member. We are committed to providing you and your family with unparalleled service and care at an affordable cost, and we pledge to keep our focus on what's most important – your overall health and wellness.

Please take a few minutes to review the information in this guide. The more informed you are, the easier it will be to get the care you need when you need it the most. Your membership card(s) and this booklet provide important information about your Plan, as well as the steps you need to take to access healthcare at one of the thousands of participating network provider locations. Your welcome information, Member Portal access and temporary member cards are contained in your Welcome Email: please print it and save a copy for reference.

If you have any questions about your Plan, activating your Membership Card, setting up your telemedicine account, pharmacy benefit, or accessing a healthcare provider, please contact a Member Care Specialist for assistance, Monday through Friday, 8 a.m. to 8 p.m. ET at (844) 834-3456.

Member Portal
Username and password credentials are needed to enter the Member's portal to update payment or personal information. Visit www.AlieraHealthcare.com and click the Member Login tab. Your user name and password are on the Welcome Email sent at the time of initial enrollment. Member Services can send you a copy of this email following confirmation of identity.

Contact Information
For general information, account management, monthly contribution, or medical needs, please contact us.

Phone: 844-834-3456

eFax: 1-404-937-6557 (+1 required for eFax)

Email: memberservices@alierahealthcare.com | memberservices@unityhealthshare.com

Online: www.alierahealthcare.com | www.unityhealthshare.com

Mail: 5901 Peachtree Dunwoody Road, Suite B-200, Atlanta Georgia 30328

Disclaimer
Unity HealthShare℠ is a faith-based medical need sharing membership. Medical needs are only shared by the members according to the membership guidelines. Our members agree to the Statement of Beliefs and voluntarily submit monthly contributions into a cost sharing account with Unity HealthShare, acting as a neutral clearing house between members. Organizations like ours have been operating successfully for years. We are including the following caveat for all to consider:

> *This publication or membership is not issued by an insurance company, nor is it offered through an insurance company. This publication or the membership does not guarantee or promise that your eligible medical needs will be shared by the membership. This publication or the membership should never be considered as a substitute for an insurance policy. If the publication or the membership is unable to share in all or part of your eligible medical needs, or whether or not this membership continues to operate, you will remain financially liable for any and all unpaid medical needs.*
>
> *This is not a legally binding agreement to reimburse any member for medical needs a member may incur, but is instead, an opportunity for members to care for one another in a time of need and to present their medical needs to other members as outlined in the membership guidelines. The financial assistance members receive will come from other members' monthly contributions that are placed in a sharing account, not from Unity HealthShare.*

PLAN SERVICES AND MEMBERSHIP AT A GLANCE

Aliera Healthcare services and Unity HealthShare cost sharing combine to create a full range of services and benefits, summarized below:

ALIERA Healthcare

PREVENTIVE CARE

As part of our solution, the plans cover medical services recommended by the USPSTF and outlined in the ACA for preventive care. There is zero out of pocket expense and no deductible to meet for any scheduled preventive care service or routine in-network check-up, pap smear, flu shot and more. It's easier to stay healthy with regular preventive care.

EPISODIC PRIMARY CARE

Primary care is at the core of an Aliera Plan, and we consider it a key step in getting and staying healthy. Our model is based on an innovative approach to care that is truly patient-centered, combining excellent service with a modern approach. This includes medical care needs such as primary care, office visits, basic eye and hearing exams, flu shots, infections, etc.

CHRONIC CARE

With a AlieraCare Premium Plan, you receive chronic care management for conditions such as diabetes, asthma, blood pressure, cardiac conditions, etc. Members' primary care assigned physicians also perform any outpatient designated services.

LABS & DIAGNOSTICS

All PCP and Urgent Care labs are included in your monthly membership. Your membership includes over 180 different lab tests to ensure the medical care you need is covered.

TELEMEDICINE

Whether sick, at work or in bed all day, a doctor is only a phone call away. Talk to a doctor on your phone or video chat and have your problem diagnosed, medicine prescribed, or if necessary, be further instructed.

With 24/7/365 access to a doctor, staying healthy has never been simpler. Reap the benefit of innovative healthcare.

PRESCRIPTION DRUG PROGRAM

The AlieraCare prescription savings program delivers significant discounts for a variety of drugs (depending on prescription), saving members an average of 55% on prescription drug purchases.

URGENT CARE

For those medical situations that can't wait or are more complex than primary care services, AlieraCare Plans offer access to urgent care facilities at hundreds of medical centers throughout the United States.

UNITY HEALTHSHARE

MEMBERSHIP

Unity HealthShare(sm) is a health care sharing ministry (HCSM) which acts as an organizational clearing house to administer sharing of health care needs for qualifying members. The Unity HealthShare membership is NOT health insurance. The membership is based on a religious tradition of mutual aid, neighborly assistance, and burden sharing. The membership does not subsidize self-destructive behaviors and lifestyles, but is specifically tailored for individuals who maintain a healthy lifestyle, make responsible choices in regards to health and care, and believe in helping others. Because Unity HealthShare is a religious organization, members are required to agree with the organizations Statement of Beliefs; see Part II of this guide for the full description and membership details.

HOSPITALIZATION

Hospitalization is covered, once the Member Shared Responsibility Amount has been met, under all the individual plans. The Per incident limit for coverage ranges from $150,000 to $1,000,000.

SURGERY

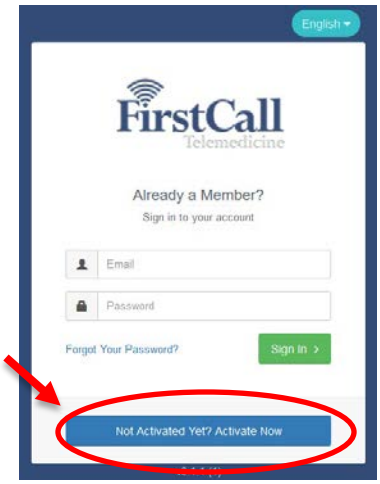
Both in-patient and out-patient procedures are covered, once the Member Shared Responsibility Amount has been met, under all individual plans. The Per incident limit for coverage ranges from $150,000 to $1,000,000.

GETTING STARTED

What does it mean? Many of the terms used in describing health cost sharing may be unfamiliar to those new to the programs and plans provided by Aliera and Unity HealthShare. Please refer to the Definition of Terms section for a quick and easy understanding of terms used in this guide and other plan documents.

1. **Activate Your Membership**
   Visit www.alierahealthcare.com to securely enter your information. Under Member Resources menu, click *Activation* and follow the instructions. If you require assistance, contact a Member Care Specialist toll-free at (844) 834-3456 or email memberservices@alierahealthcare.com.

2. **Set Up Your Telemedicine Account**
   Follow the steps below to set up your telemedicine account. If you have not activated your Membership Card, or if your Membership fees are not paid up to date, you are not eligible to set up your telemedicine account.



Set up your account (Primary Member)
Visit www.firstcalltelemed.com, Click “Set up account.” Follow the online instructions and provide the required information, including your medical history.

Set up minor dependents (17 years or younger)
Log in to your account and click “My Family” on the top menu. Follow the online instructions to provide the necessary information and complete your dependent’s medical history.

Set up adult dependents (18 – 26 years)
Adult dependents must set up their own account. Visit the website and click “Set up account.” Follow the online instructions to provide the required information and to complete your medical history.

3. **Review Your Benefits**
   This guide contains the information you need to understand each benefit available with your Plan. Keep your Member Card with you at all times; the contact number for your telemedicine provider is printed on your card. You must always contact your telemedicine provider before seeking medical attention.

PART I

How to Use Your Membership

THE TELEMEDICINE PROGRAM

More than 80% of primary medical conditions can be resolved by your telemedicine provider. Members are required to contact their telemedicine provider first for quick, convenient medical assistance. The contact information for your telemedicine provider is found on your member card from the telemedicine provider.

Benefits of the Telemedicine Program

- At home, at work, or while traveling in the US, speak to a telemedicine doctor from anywhere, anytime, on the go!
- 24/7 access to a doctor via face-to-face internet consultation or by phone is available for you and dependents on your Plan.
- Speak with the next available doctor or schedule an appointment for a more convenient time.
- Telemedicine doctors typically respond within 15 minutes of your call.
- Save time and money by avoiding expensive emergency room visits, waiting for an appointment, or driving to a local facility.
- Telemedicine consultations are free for you and dependents on your Plan.
- Telemedicine providers can treat conditions such as:
  - ► Cold and flu symptoms
  - ► Bronchitis
  - ► Allergies
  - ► Poison ivy
  - ► Pink eye
  - ► Urinary tract infections
  - ► Respiratory infections
  - ► Sinus problems
  - ► Ear infections; and more!

Antibiotics are not always the answer to treat a medical condition. Doctors may choose not to prescribe antibiotics for viral illnesses such as common colds, sore throats, coughs, sinus infections, and the flu.

If the telemedicine doctor recommends that you see your PCP or visit an urgent care facility, contact Aliera's Concierge Service, and a member care specialist will be happy to assit you with scheduling an appointment.

CONCIERGE SERVICE & CARE COORDINATION

Our care coordination service is designed to help members navigate the healthcare system effectively and efficiently. Aliera's Concierge Service smoothly coordinates your medical care. Members are encouraged to contact Aliera's Concierge Service for scheduling appointments for all services.

How to Use the Concierge Service

1. Always call your telemedicine provider first when you have a medical issue. The contact information for your telemedicine provider is found on your membership card from the telemedicine provider.
2. If the telemedicine provider is unable to resolve your medical issue and recommends further treatment, the Member may contact Aliera's Concierge Service at (844) 834-3456 for coordination of your care and scheduling of appointments with doctors and urgent care facilities. Members are not required to use the concierge but it is available for your convenience.
3. Be sure to have your Membership number available when contacting Aliera's Concierge Service. Membership numbers are located on the front of your member card.
4. When you arrive for your appointment at the provider's location, please present your Membership Card and one photo ID. The front desk admin will check your eligibility status. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the provider.
5. If your PCP makes a referral to a specialist or another provider, contact Aliera's Concierge Service at (844) 834-3456 to schedule and coordinate your visit. Emergency room, hospitalization, and specialty services are described under Part II (HCSM) and Part III (Eligible Needs and Limitations) of this document.

PREVENTIVE CARE

It's easier to stay healthy when you have regular preventive care. Members have no out-of-pocket expenses for preventive services, which include, but are not limited to, routine in-network checkups, pap smears, flu shots and more.

How to Use Preventive Care Services

1. Download the Preventive Healthcare Guidebook from the link found in your Welcome email or visit us online at www.AlieraHealthcare.com. or www.unityhealthshare.com
2. Members do not need to call their telemedicine provider to schedule preventive care. However, all preventive care appointments must be scheduled through Aliera's Concierge Service at (844) 834-3456.
3. Aliera cannot guarantee that a provider will accept an Aliera/Unity Plan if the Member fails to contact our Concierge Service first. Please allow 7–10 days for preventive care appointments.
4. Immunization, imaging, and radiological services are provided at select network centers in each state. Call Aliera's Concierge Service to schedule an appointment. Please allow up to three weeks for an appointment.
5. Upon arrival at a PCP, please present your Membership Card and one photo ID. The front desk admin will check your eligibility status. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the provider.
6. Preventive health services must be appropriate for the covered person and follow the guidelines below:
    - **a)** In general – those of the U.S. Preventive Services Task Force that have an A or B rating.
    - **b)** For immunizations – those of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
    - **c)** For preventive care and screenings for children and adolescents – those of the Health Resources and Services Administration.
    - **d)** For preventive care and screenings for women – those of the Health Resources and Services Administration that are not included in section (A) of the U.S. Preventive Services Task Force schedule.

LABS AND DIAGNOSTICS

Aliera and Unity Members have access to lab work in the convenience of their provider's office or at any of the 2,000+ Quest lab network locations nationwide.

- Convenience: Aliera and Unity partner with **Quest Diagnostics** nationwide; you can be tested in a doctor's office or at any of the 2,000+ testing centers across the US.
- Expertise: With more than 40,000 employees, including nearly 900 MDs, PhDs, and other specialists, Quest assures the highest quality medical services.
- Services: Quest offers more than 3,000 tests, from basic to the most complex, including many you can't get elsewhere.
- Innovation: Quest introduced more than 100 tests – many of which were the first available on the market to help detect numerous diseases.

How to Access MyQuest

MyQuest allows you to schedule appointments 24/7 for testing, access your test results, and track your health conditions using your computer or smartphone.

1. To set up your MyQuest account, visit www.myquest.questdiagnostics.com. Click "Sign Up," then "Register Now."
2. Follow the online instructions and provide your information to complete the patient registration.
3. After setting up your MyQuest account, you can get Advanced Access, which allows you to see your test results as far back as 2010, including graphic representations of how your health is trending over time.
4. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the services provided by Quest.
5. Visit www.Alierahealthcare.com to locate your nearest Quest facility. Click the Network tab and select "Lab Test Locations" from the drop-down menu.

URGENT CARE

Your membership raises the standard of healthcare by putting individuals first, treating them with clinical excellence, and focusing on their well-being. Members can access services from hundreds of urgent care network facilities throughout the United States.

- Plans vary, and can provide up to two (2) visits, where consult fee may apply.
- See appendix for your specific plan details.
- X-rays are included, and subject to a read fee, per X-ray read.

How to Use the Urgent Care Service

1. Call 911 if your emergency is life threatening; otherwise, please contact your telemedicine provider first via telephone or a scheduled face-to-face internet conference. Your provider will determine if your medical condition can be resolved without visiting a local urgent care facility.
2. If your medical issue cannot be resolved after your free consultation with a telemedicine doctor, call Aliera's Concierge Service at (844) 834-3456. A coordinator will call the urgent care facility ahead of your arrival to manage a smooth check-in.
1. After 6 p.m., contact an after-hours Member Care Specialist at (844) 834-3456. If you are unable to connect with the Concierge Service, please go to the nearest in-network urgent care facility. To locate a facility, visit www.AlieraHealthcare.com, click "Network" to find the nearest urgent care facility.
3. Upon arrival at an urgent care facility, present your Membership Card and one photo ID. The front desk admin will check your eligibility status. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the provider.
4. At time of service, payment of $20 (on average) is due for the consultation, and a $25 read fee for X-rays if needed may be due. Costs may be higher depending on your state and provider.

If Urgent Care Services are Unavailable

If an urgent care facility in the network is unavailable to a Member requiring immediate urgent care, please adhere to the following procedure:

2. If unable to connect with the Concierge Service, the Member must go to the nearest in-network urgent care facility. Visit www.AlieraHealthcare.com. Click "Network" to find the nearest urgent care facility under MultiPlan.
3. If the nearest in-network facility is more than 20 miles away from the Member, is closed (after 6:00 p.m.), or is no longer in business, the Member should seek out the nearest urgent care facility or hospital emergency room to receive urgent medical attention.
4. Unity HealthShare products are not health insurance plans and Aliera nor Unity is responsible for payment to out-of-network urgent care or hospital emergency room facilities. The Member is solely responsible for such urgent care medical payments. Aliera and or Unity maintains an allotment fund designed to provide a Member with supplemental payment assistance (ex gratia) in the amount of $105.00 to offset the cost incurred at an out-of-network urgent care or hospital emergency room facility. This monetary assistance is limited to one visit per year, per Member. Payment is made directly to the Member after confirmation of submitted proof of urgent care necessity and unavailability of an in-network provider.

PRIMARY CARE FOR SICK CARE

In addition to our urgent care services, many of our plans offer Members under the age of 65 episodic primary care or sick care.

- Plans with annual PCP visits include one (1), three (3), or five (5) visits, each with consult fee ranging from $20 to $40 in certain markets.
- For convenience, some clinics are open evenings and weekends.

How to Use Primary Care Service for Sick Care

1. Contact your telemedicine provider to speak with a US board-certified doctor via telephone or a scheduled face-to-face internet conference.
2. The telemedicine doctor may be able to resolve your medical issue and prescribe medication if needed. More than 80% of primary medical conditions can be resolved by your telemedicine provider.
3. If your medical issue cannot be resolved after your free consultation with the telemedicine doctor, you can call Aliera's Concierge Service at (844) 834-3456 to schedule an appointment with your local provider if you wish. You may also make your own appointment.
4. Upon arrival at a clinic, present your Membership Card and one photo ID. The front desk admin will check your eligibility status before you can see a provider. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the provider.
5. At the time of service, a payment of $20 (on average) is due for the consultation, and a $25 read fee for X-rays, per X-ray read, if needed. Costs may be higher depending on your state and provider.

PRIMARY CARE FOR SICK CARE AND CHRONIC MAINTENANCE

Plan Members are eligible to visit an in-network physician for an annual physical exam, chronic maintenance, and preventive services.

- ► The Member is eligible for an annual physical exam after nine (9) months of continuous coverage. All other preventive care as directed by a physician is available immediately.
- ► For convenience, some clinics are open evenings and weekends.

How to Use Primary Care Service for Sick and Chronic Care

1. Contact your telemedicine provider to speak with a US board-certified doctor via telephone or a scheduled face-to-face internet conference.
2. The telemedicine doctor may be able to resolve your medical issue and prescribe medication if needed. More than 80% of primary medical conditions can be resolved by your telemedicine provider.
3. If your medical issue cannot be resolved after your free consultation with the telemedicine doctor, you can call Aliera's Concierge Service at (844) 834-3456 to schedule an appointment with your local provider if you wish. You may make your own appointment.
4. Upon arrival at a clinic, present your Membership Card and one photo ID. The front desk admin will check your eligibility status before you can see a provider. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the provider.
5. At the time of service, a payment of $20 (on average) is due for the consultation, and a $25 read fee for X-rays, per X-ray read, if needed. Costs may be higher depending on your state and provider.

SPECIALTY CARE

Unity healthshare members are required to obtain referrals to visit a specialist, except for women in need of gynacological care for routine medical needs.

HOSPITALIZATION

Your hospitalization cost sharing is provided to you in an effort to alleviate the stress and strain during times of crisis or medical needs.

1. Members are required to pre-authorize all hospitalization services and visits unless it is an obvious medical emergency. Please see pre-authorization section for instructions
2. You are responsible for your MSRA first before cost sharing is available to reimburse the providers and hospital facilities.
3. Several plans allow for fixed cost sharing in the emergency room. Please see Appendix A for your exact plan details.

PPO NETWORK

With a growing nationwide PPO network of more than 1,000,000 healthcare professionals and more than 6,000 facilities, Multiplan PHCS network offers Plan Members a range of quality choices to help them stay healthy.

- Search for providers by distance, cost efficiency, and specialty.
- While some Plans do not cover specialty services, Aliera's Concierge Service in unison with Unity HealthShare℠ will help you find doctors in 22 different medical specialties who meet certain cost and quality measures. See specific Plan details for your Plan's Specialty Services coverage.

Find a Network Healthcare Professional

- Visit www.Multiplan.com and search for a provider by zip code, city, county, state, or other search criteria.

Call Aliera Healthcare at (844) 834-3456 or Unity Healthshare at (800)-847-9794. Select the Provider Coordination Department and a care coordinator will help you navigate the healthcare process effectively and efficiently.

PART II

How Your Healthcare Cost Sharing Ministry (HCSM) Works

MEMBERSHIP OVERVIEW

Unity HealthShare[SM] is a clearing house that administers voluntary sharing of healthcare needs for qualifying members. The membership is based on a tradition of mutual aid, neighborly assistance, and burden sharing. The membership does not subsidize self-destructive behaviors and lifestyles, but is specifically tailored for individuals who maintain a healthy lifestyle, make responsible choices in regards to health and care, and believe in helping others. The Unity HealthShare[SM] membership is not health insurance.

Guidelines Purpose and Use

The HCSM guidelines are provided as an outline for eligible needs in which contributions are shared in accordance with the membership's escrow instructions. They are not for the purpose of describing to potential contributors the amount that will be shared on their behalf and do not create a legally enforceable right on the part of any contributor. Neither these guidelines nor any other arrangement between contributors and Unity HealthShare[SM] creates any rights for any contributor as a reciprocal beneficiary, as a third-party beneficiary, or otherwise.

The edition of the guidelines in effect on the date of medical services supersedes all previous editions of the guidelines and any other communication, written or verbal. With written notice to the general membership, the guidelines may change at any time based on the preferences of the membership and on the decisions, recommendations, and approval of the Board of Trustees.

An exception to a specific provision only modifies that provision and does not supersede or void any other provisions.

Individuals Helping Individuals

Contributors participating in the membership help individuals with their medical needs. Unity HealthShare[SM] facilitates in this assistance and acts as an independent and neutral escrow agent, dispersing monthly contributions as described in the membership escrow instructions and guidelines.

MEMBERSHIP QUALIFICATIONS

To become and remain a member of Unity HealthShare[SM], a person must meet the following criteria:

Religious Beliefs and Standards. The person must have a belief of helping others and/or maintaining a healthy lifestyle as outlined in the Statement of Beliefs contained in the membership application. If at any time during participation in the membership, a violation of the Statement of Beliefs is found, the individual not honoring this standard may be subject to removal from participation in the membership.

Medical History. The person must meet the criteria to be qualified for a membership on his/her application date, based on the criteria set forth in this guidebook and the membership application.

If, at any time, it is discovered that a member did not submit a complete and accurate medical history on the membership application, the criteria set forth in the Membership Eligibility Manual on his/her application date will be applied, and could result in either a retroactive membership limitation or a retroactive denial to his/her effective date of membership.

Members may apply to have a membership limitation removed by providing medical evidence that they qualify for such removal according to the criteria set forth in the Membership Eligibility Manual. Membership limitations and denials can be applied retroactively but cannot be removed retroactively.

Application, Acceptance, and Effective Date. The person must submit a membership application and be accepted into the membership by meeting the criteria of the Member Eligibility Manual. The membership begins on a date specified by Unity HealthShare[SM] in writing to the member.

Dependent(s). A dependent may participate under a combined membership with the head of household.

A dependent who wishes to continue participating in the membership but who no longer qualifies under a combined membership must apply and qualify for a membership based on the criteria set forth in the Membership Eligibility Manual.

Under a combined membership, the head of household is responsible for ensuring that everyone participating under the combined membership meets and complies with the Statement of Beliefs and all guideline provisions.

Financial Participation. Monthly contributions are requested to be received by the 1st or 15th of each month depending on the member's effective date. If the monthly contribution is not received within 5 days of the due date, an administrative

fee will be assessed to track, receive, and post the monthly contribution. If the monthly contribution is not received by the end of the month, a membership will become inactive as of the last day of the month in which a monthly contribution was received.

Any member who has a membership that has become inactive will be able to reapply for membership under the terms outlined to them in writing by Unity HealthShare[SM]. Any member who submits a monthly contribution in such a manner as to have a membership become inactive three times will not be able to reapply for membership.

Needs occurring after a member's inactive date and before they reapply are not eligible for sharing.

Administrative Costs. The fees for the first two months of membership are applied as an administrative fee. Beginning the third month of membership and each month following, a fee of $25 is assigned to administrative costs from each contribution amount regardless of family size. A single, couple, or family membership all contribute $25 from their monthly contribution for administration. In addition, the annual membership dues are also utilized by Unity HealthShare[SM] to defray administrative costs.

When Available Shares are less than Eligible Needs. In any given month, the available suggested share amounts may or may not meet the eligible needs submitted for sharing. If a member's eligible bills exceed the available shares to meet those needs, the following actions may be taken:

1. A pro-rata sharing of eligible needs may be initiated, whereby the members share a percentage of eligible medical bills within that month and hold back the balance of those needs to be shared the following month.
2. If the suggested share amount is not adequate to meet the eligible needs submitted for sharing over a 60-day period, then the suggested share amount may be increased in sufficient proportion to satisfy the eligible needs. This action may be undertaken temporarily or on an ongoing basis.

Other Criteria. Children under the age of 18 may not qualify for membership. Non-U.S. citizens may qualify for membership as determined by Unity HealthShare[SM] on a case-by-case basis.

MONTHLY CONTRIBUTIONS

Monthly contributions are voluntary contributions or gifts that are non-refundable. As a non-insurance membership, neither Unity HealthShare[SM] nor the membership are liable for any part of an individual's medical need. All contributors are responsible for their own medical needs. Although monthly contributions are voluntary contributions or gifts, there are administrative costs associated with monitoring the receipt and disbursement of such contributions or gifts. Therefore, declined credit cards, returned ACH payments, or any contribution received after the 1st or 15th of each month will incur an administrative fee.

Members wishing to change to a membership type other than that which they are currently participating may, at the discretion of Unity HealthShare[SM], be required to submit a new signed and dated membership application for review. Membership type changes can only become effective on the first of the month after the new membership application has been approved.

Contributors wishing to discontinue participation in the membership must submit the request in writing by the 20th day of the month before which the contributions will cease. The request should contain the reason why the contributor is discontinuing participation in the membership. Should the contributor fail to follow these guidelines as they pertain to discontinuing their participation in the membership and later wishes to reinstate their membership, unsubmitted contributions from the prior participation must be submitted with a new application.

A member is not eligible for cost sharing when a member:

a) has paid a monthly contribution and then cancels within 30 days of receiving medical attention, except within the last 90 days of the membership term;

b) receives care within the first 60 days of the plan and cancels his membership within 30 days of receiving medical care;

c) receives or requires surgery within the first 60 days of becoming a member except in the case of an accident.

EARLY VOLUNTARY TERMINATION

Members of the Unity HealthShare may terminate their membership at any time, with 30 days prior notice. Unity HealthShare plans are not a substitute for "short term medical plans". Medical expenses incurred during the term of the membership and followed by early voluntary termination within 90 days of incurring medical expenses, will be reviewed

and may not be eligible for cost sharing, where the early termination was not as a direct result of affordability issues with the health sharing program.

STATEMENT OF BELIEFS

At the core of what we do, and how we relate to and engage with one another as a community of people, is a set of common beliefs. Our Statement of Shared Beliefs is as follows:

1. We believe that our personal rights and liberties originate from God and are bestowed on us by God.
2. We believe every individual has a fundamental religious right to worship God in his or her own way.
3. We believe it is our moral and ethical obligation to assist our fellow man when they are in need per our available resources and opportunity.
4. We believe it is our spiritual duty to God and our ethical duty to others to maintain a healthy lifestyle and avoid foods, behaviors, or habits that produce sickness or disease to ourselves or others.
5. We believe it is our fundamental right of conscience to direct our own healthcare in consultation with physicians, family, or other valued advisors.

DEFINITIONS OF TERMS

Terms used throughout the Member Guide and other documents are defined as follows:

Affiliated Practitioner. Medical care professionals or facilities that are under contract with a network of providers with whom Unity HealthShare[SM] works. Affiliated providers are those that participate in the PHCS network. A list of providers can be found at http://www.multiplan.com.

Application Date. The date Unity HealthShare[SM] receives a complete membership application.

Combined Membership. Two or more family members residing in the same household.

Contributor. Person named as head of household under the membership.

Dependent. The head of household's spouse or unmarried child(ren) under the age of 26 who are the head of household's dependent by birth, legal adoption, or marriage who is participating under the same combined membership.

Eligible. Medical needs that qualify for voluntary sharing of contributions from escrowed funds, subject to the sharing limits.

Escrow Instructions. Instructions contained on the membership application outlining the order in which voluntary monthly contributions may be shared by Unity HealthShare[SM].

Guidelines. Provided as an outline for eligible medical needs in which contributions are shared in accordance with the membership's escrow instructions.

Head of Household. Contributor participating by himself for herself; or the husband or father that participates in the membership; or the wife or mother if the husband does not participate in the membership.

Licensed Medical Physician. An individual engaged in providing medical care and who has received state license approval as a practicing Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

Medically Necessary. A service, procedure, or medication necessary to restore or maintain physical function and is provided in the most cost-effective setting consistent with the member's condition. Services or care administered as a precaution against an illness or condition or for the convenience of any party are not medically necessary. The fact that a provider may prescribe, administer, or recommend services or care does not make it medically necessary, even if it is not listed as a membership limitation or an ineligible need in these guidelines. To help determine medical necessity, Unity HealthShare[SM] may request the member's medical records and may require a second opinion from an affiliated provider.

Member(s). A person(s) who qualifies to receive voluntary sharing of contributions for eligible medical needs per the membership clearing house instructions, guidelines, and membership type.

Member Shared Responsibility Amounts (MSRA). The amounts of an eligible need that do not qualify for sharing because the member is responsible for those amounts.

Membership. All members of Unity HealthShare[SM].

Membership Eligibility Manual. The reference materials that contain the criteria used to determine if a potential member is eligible for participation in the membership and if any membership limitations apply.

Membership Type. HCSM sharing options are available with different member shared responsibility amounts (MSRA) and sharing limits as selected in writing on the membership application and approved by Unity HealthShare[SM].

Monthly Contributions. Monetary contributions, excluding the annual membership fee, voluntarily given to Unity HealthShare[SM] to hold as an escrow agent and to disburse according to the membership escrow instructions.

Need(s). Charges or expenses for medical services from a licensed medical practitioner or facility arising from an illness or accident for a single member.

Non-affiliated Practitioner. Medical care professionals or facilities that are not participating within our current network.

Pre-existing Condition. Any illness or accident for which a person has been diagnosed, received medical treatment, been examined, taken medication, or had symptoms within 24 months prior to the application date. Symptoms include but are not limited to the following: abnormal discharge or bleeding; abnormal growth/break; cut or tear; discoloration; deformity; full or partial body function loss; obvious damage, illness, or abnormality; impaired breathing; impaired motion; inflammation or swelling; itching; numbness; pain that interferes with normal use; unexplained or unplanned weight gain or loss exceeding 25% of the total body weight occurring within a six-month period; fainting, loss of consciousness, or seizure; abnormal results from a test administered by a medical practitioner.

Usual, Customary and Reasonable (UCR). The lesser of the actual charge or the charge most other providers would make for those or comparable services or supplies, as determined by Unity HealthShare[SM].

CONTRIBUTORS' INSTRUCTIONS AND CONDITIONS

By submitting monthly contributions, the contributors instruct Unity HealthShare[SM] to share clearing house funds in accordance with the membership instructions. Since Unity HealthShare[SM] has nothing to gain or lose financially by determining if a need is eligible or not, the contributor designates Unity HealthShare[SM] as the final authority for the interpretation of these guidelines. By participation in the membership, the member accepts these conditions as enforceable and binding.

Medical Expenses not generally shared by HCSM

Only needs incurred on or after the membership effective date are eligible for sharing under the membership instructions. The member (or the member's provider) must submit a request for sharing in the manner and format specified by Unity HealthShare[SM]. This includes, but is not limited to, a Need Processing Form, standard industry billing forms (HCFA 1500 and/or most recent UB form), and may include medical records. All participating members have a responsibility to abide by the Members' Rights and Responsibilities published by Unity HealthShare[SM] and included at the end of these guidelines.

Needs arising from any one of the following are not eligible for sharing under the membership clearing house instructions:

1. Any medical care outside of a hospital, except in the case of a needed surgery due to an accident. Members may be able to use out-patient facilities based upon the nature of the medical need and at the sole discretion of Unity HealthShare[SM]. In addition, some plans of Unity HealthShare[SM] include primary, urgent ,and specialty care. See the Appendix for your plan specifics.
2. Treatment or referrals received or obtained from any family member including, but not limited to, father, mother, aunt, uncle, grandparent, sibling, cousin, dependent, or any in-laws.
3. Pre-existing Conditions. Pre-existing conditions may vary based on plan option. Please see Appendix for specific plan details.
4. Illness or injuries caused by member negligence or for which the member has acted negligently in obtaining treatment. This could be documented by, but is not limited to, review of medical records or treatment plans by a licensed medical physician.
5. Procedures or treatments that are not recognized and approved by the American Medical Association (AMA) or that are illegal. Includes procedures not approved by the AMA for a given application, procedures still in clinical trials, procedures that are classified as experimental, or unproven interventions and therapies.
6. Lifestyles or activities engaged in after the application date that conflicts with the Statement of Beliefs (on the membership application).
7. Transportation (e.g., ambulance, etc.) for conditions that are not life-threatening, unless failure to immediately transport the member will seriously jeopardize the member's life; the additional expense for transportation to a facility that is not the nearest facility capable of providing medically necessary care; or charges in excess of $10,000 for transportation by air.

8. Congenital birth defects.
9. Elective cosmetic surgery.
10. Breast implants (placement, replacement, or removal) and complications related to breast implants, including abnormal mammograms, unless related to an otherwise eligible need.
11. Elective abortion of a viable fetus/embryo, unless medically necessary to protect the life of the mother.
12. Infertility testing or treatment, as well as any birth control measures to prevent conception (i.e., the pill, IUDs, shots, etc.)
13. Sterilization or reversals (vasectomy and tubal ligation).
14. Hysterectomy without first obtaining two independent opinions (neither physician may be a partner or other affiliate of the other). Both doctors must examine the patient prior to surgery and both must find that a hysterectomy is medically necessary. The member is responsible to ensure that both physicians submit medical necessity to Unity HealthShare℠ prior to surgery. Failure to follow these procedures will result in a finding of ineligibility for sharing by the membership.
15. Weight control and management including nutritional counseling for weight loss, weight gain, or health maintenance.
16. Hospital stays exceeding 60 days per medical need or additional charges for a private hospital room if a semi-private hospital room is available.
17. Any exams, physicals, or tests for which there are no specific medical symptoms, diagnosis in advance, or risk assessment testing.
18. Adult immunizations, HPV immunizations, and flu shots unless covered under an Aliera Healthcare part of the plan.
19. Chelation.
20. Physical therapy or occupational therapy that is not pre-authorized. Pre-authorized treatments are limited to a combined 6 visits in any calendar year.
21. Charges for emergency room visits and/or surgical removal for foreign objects placed in nose or ears by a child over five (5) years of age. Removal of foreign objects that can be done in an office setting will be reviewed under regular MSRAs or the Office Visit consult fee options.
22. Medication or procedures not requiring a prescription.
23. Purchase or rental of durable or reusable equipment or devices (e.g. oxygen, orthotics, hearing aids, prosthetics, and external braces), including associated supplies, diagnostic testing, or office visits.
24. Needs for active members submitted 9 months after the date of treatment. Needs for inactive members submitted 6 months after the date of treatment.
25. Dental services and procedures, including periodontics, orthodontics, temporomandibular joint disorder (TMJ), or orthognathic surgery. Includes hospital charges for dental work done under general anesthesiology. Dental work required during surgery from an accident shall be eligible for cost sharing when the dental work is required after an accident and while the member is still admitted to a hospital.
26. Optometry, vision services, glasses, contacts, supplies, vision therapy, refraction services, or office visits.
27. Psychiatric or psychological counseling, testing, treatment, medication, and hospitalization.
28. Mental or psychiatric health, learning disability, developmental delay, autism, behavior disorders, eating disorders, neuropsychological testing, alcohol/substance abuse counseling, attention deficit disorder, or hyperactivity.
29. Speech therapy (except for a deficit arising from stroke/trauma).
30. Circumcisions.
31. Self/inflicted or intentional injuries.
32. Acts of war.
33. Exposure to nuclear fuel, explosives, or waste.
34. Occupational injury resulting from an injury incurred while performing any activity for profit.
35. Consumption of a prescription drug not prescribed for the member or prescription drug prescribed for the member and taken in excess that causes an adverse reaction; illicit drug use by a member.
36. Illness or injury caused by the illegal activities of the member or the member's family, including misdemeanors and felonies, regardless of whether or not charges are filed.
37. Treatment, care, or services that is not medically necessary.
38. Emergency room services, unless treatment at an emergency room is the only legitimate option because of the severity of the condition and lack of availability of treatment at an alternative facility.
39. Sexually transmitted diseases.
40. Diseases, including HIV/AIDS, due to tattoos, body piercing, or life-style choices.
41. Allergy testing or immunotherapy treatment.
42. Second surgeries are eligible for sharing based on member's treatment plan and are subject to third party case management approval. Second surgeries on a previously eligible surgical need are not eligible unless the

member has followed through with the treatment plan laid out for him or her by their physician or complications occur within 15 days of eligible surgery.

43. Genetic testing and counseling.
44. Handling charges, conveyance fees, stat fees, shipping/handling fees, administration fees, missed appointment fees, telephone/email consultations, or additional charges for services supplied in an after-hours setting.
45. Drug testing unless required by membership.
46. Sexual dysfunction services.
47. Cancer sharing eligibility is different based on plan option chosen. AlieraCare plans have a 12 month wait period for cancer. Sharing is available the 1st day of the 13 month of continuous membership. Any pre-existing or recurring cancer condition is not eligible for sharing. Cancer sharing will not be available for individuals who have cancer at the time of or five (5) years prior to application. If cancer existed outside of the 5-year time frame of a pre-exisitng look-back, the following must be met in the five (5) years prior to application, to be eligible for future, non-recurring cancer incidents. 1. The condition had not been treated nor was future treatment prescribed/planned; 2. The condition had not produced harmful sypmtoms (only benign symptoms); 3. The condition had not deteriorated.
48. Adenoid removal surgery eligible for sharing only at 50% if member has had a prior surgery to remove tonsils and the adenoids were not removed at the same time.
49. Personal aircraft includes hang gliders, parasails, ultra-lights, hot air balloons, sky/diving, and any other aircraft not operated by a commercially licensed public carrier.
50. Extreme sports: Sports that voluntarily put an individual in a life-threatening situation. Sports such as but not limited to “free climb” rock climbing, parachuting, fighting, matrial arts, racing, cliff diving, powerboat racing, air racing, motorcycle racing, extreme skiing, wingsuit, etc…

First 60 Days of Participation. *For sixty (60) days after Enrollment Date as a Sharing Member, medical expenses for any reason, other than accidents, illness or injury, are not eligible for sharing among members.*

PRE-AUTHORIZATION REQUIRED

Non-Emergency Surgery, Procedure, or Test. The member must have the following procedures or services pre-authorized as medically necessary prior to receiving the service. Failure to comply with this requirement will render the service not eligible for sharing.

Hospitalizations. Non-emergency prior to admission; emergency visits notification to Unity HealthShare℠ within 48 hours.

- MRI studies/CT scans/Ultrasounds
- Sleep studies must be completed in one session
- Physical or occupational therapy
- Speech therapy under limited circumstances only
- Cardiac testing, procedures, and treatments
- In-patient cancer testing, procedures, and treatments
- Infusion therapy within facility
- Nuclide studies
- EMG/EEG
- Ophthalmic procedures
- ER visits, emergency surgery, procedure, or test: Non-emergency use of the emergency room is not eligible for sharing. Unity HealthShare℠ must be notified of all ER visits within 48 hours. Medical records will be reviewed for all ER visits to determine eligibility. An emergency is defined as treatment that must be rendered to the patient immediately for the alleviation of the sudden onset of an unforeseen illness or injury that, if not treated, would lead to further disability or death. Examples of an emergency include, but are not limited to, severe pain, choking, major bleeding, heart attack, or a sudden, unexplained loss of consciousness.

Eligibility for Cancer Needs. In order for needs related to cancer hospitalization of any type to be eligible (e.g. breast, colorectal, leukemia, lymphoma, prostate, skin, etc.), the member must meet the following requirements:

The member is required to contact Unity HealthShare℠ within 30 days of diagnosis. If the member fails to notify Unity HealthShare℠ within the 30-day time frame, the member will be responsible for 50% of the total allowed charges after the MRSA(s) has been assessed to the member for in-patient cancer hospitalization.

Early detection provides the best chance for successful treatment and in the most cost effective manner. Effective January 1, 2017, the membership will require that all members aged 40 and older receive appropriate screening tests every other year – mammogram or thermography and pap smear with pelvic exams for women and PSA testing for men.

Failure to obtain biannual mammograms and gynecological tests listed above for women or PSA tests for men will render future needs for breast, cervical, endometrial, ovarian, or prostate cancer ineligible for sharing.

DISPUTE RESOLUTION AND APPEAL

Unity HealthShare[SM] is a voluntary association of like-minded people who come together to assist each other by sharing medical expenses. Such a sharing and caring association does not lend itself well to the mentality of legally enforceable rights. However, it is recognized that differences of opinion will occur, and that a methodology for resolving disputes must be available. Therefore, by becoming a Sharing Member of Unity HealthShare[SM], you agree that any dispute you have with or against Unity HealthShare[SM], its associates, or employees will be settled using the following steps of action, and only as a course of last resort.

If a determination is made with which the sharing member disagrees and believes there is a logically defensible reason why the initial determination is wrong, then the sharing member may file an appeal.

A. 1st Level Appeal. Most differences of opinion can be resolved simply by calling Unity HealthShare[SM] who will try to resolve the matter within ten (10) working days in writing.

B. 2nd Level Appeal. If the sharing member is unsatisfied with the determination of the member services representative, then the sharing member may request a review by the Internal Resolution Committee, made up of three Unity HealthShare[SM] officials: the needs processing manager, the assistant director, and the executive director. The appeal must be in writing, stating the elements of the dispute and the relevant facts. Importantly, the appeal should address all of the following:

1. What information does Unity HealthShare[SM] have that is either incomplete or incorrect?
2. How do you believe Unity HealthShare[SM] has misinterpreted the information already on hand?
3. Which provision in the Unity HealthShare[SM] Guidelines do you believe Unity HealthShare[SM] applied incorrectly?

Within thirty (30) days, the Internal Resolution Committee will render a written decision.

C. 3rd Level Appeal. Should the matter remain unresolved, then the aggrieved party may ask that the dispute be submitted to three sharing members in good standing and randomly chosen by Unity HealthShare[SM], who shall agree to review the matter and shall constitute an External Resolution Committee. Within thirty (30) days the External Resolution Committee shall render their opinion in writing.

D. Final Appeal. If the aggrieved sharing member disagrees with the conclusion of his/her fellow sharing members, then the aggrieved party may ask that the dispute be submitted to a medical expense auditor, who shall have the matter reviewed by a panel consisting of personnel who were not involved in the original determination and who shall render their opinion in writing within thirty (30) days.

E. Mediation and Arbitration. If the aggrieved sharing member disagrees with the conclusion of the Final Appeal Panel, then the matter shall be settled by mediation and, if necessary, legally binding arbitration in accordance with the Rules of Procedure for Christian Conciliation of the Institute for Christian Conciliation, a division of Peacemaker Ministries. Judgment upon an arbitration decision may be entered in any court otherwise having jurisdiction. Sharing members agree and understand that these methods shall be the sole remedy for any controversy or claim arising out of the Sharing Guidelines and expressly waive their right to file a lawsuit in any civil court against one another for such disputes, except to enforce an arbitration decision. Any such arbitration shall be held in Fredericksburg, Virginia, subject to the laws of the Commonwealth of Virginia. Unity HealthShare[SM] shall pay the fees of the arbitrator in full and all other expenses of the arbitration; provided, however, that each party shall pay for and bear the cost of its own transportation, accommodations, experts, evidence, and legal counsel, and provided further that the aggrieved sharing member shall reimburse the full cost of arbitration should the arbitrator determine in favor of Unity HealthShare[SM] and not the aggrieved sharing member. The aggrieved sharing member agrees to be legally bound by the arbitrator's decision. The Rules of Procedure for Christian Conciliation of the Institute for Christian Conciliation, a division of Peacemaker Ministries, will be the sole and exclusive procedure for resolving any dispute between individual members and Unity HealthShare[SM] when disputes cannot be otherwise settled.

PART III

Your Summary of Cost Sharing, Eligible Needs, & Limits

See the Appendix for other limits and conditions of sharing by plan

MEDICAL EXPENSES COVERED*

Medical Expenses Eligible for Sharing. Medical costs are shared on a per person per incident basis for illnesses or injuries incurring medical expenses after the membership effective date when medically necessary and provided by or under the direction of licensed physicians, osteopaths, urgent care facilities, clinics, emergency rooms, or hospitals (inpatient and outpatient), or other approved providers of conventional or naturopathic care. Unless otherwise limited or excluded by these Guidelines, medical expenses eligible for sharing include, but are not limited to, physician and hospital services, emergency medical care, surgical procedures, medical testing, X-rays, ambulance transportation, and prescriptions. Co-expenses do not apply towards a members MSRA.

1. **Telemedicine.** Telemedicine is included in most programs offered by Unity HealthShare[SM] and Aliera Healthcare as your first line of defense. Your membership provides you and your family 24/7/365 access to a U.S. Board certified medical doctor.
2. **Preventive.** Most programs from either Unity Healthshare[SM] or Aliera provide everyone with the necessities of the 63 preventive care services as outlined by the United States Preventive Task force. (Excludes CarePlus Advantage.) Preventive care includes the PCP office visit and does not require a co-expense or consult fee.
3. **Labs & Diagnostics.** Your labs and diagnostics are covered when visiting a PCP or urgent care facility in network when your plan includes primary and urgent care. For labs at hospitals or other facilities, your MSRA will apply and you will be required to pay a co-expense of $25.
4. **Urgent Care.** If your plan provides cost sharing for urgent care, you will have the added benefit of enjoying the ability to choose an urgent care facility in lieu of an emergency room. See the Appendix for any urgent care options and any limitations to plan.
5. **Primary Care.** Depending on your plan choice, primary care is at the core of preventing medical issues from escalating into a more catastrophic need. See Appendix for the specific plan details.
6. **Specialty Care.** Specialty care is included in most plans, but has limits defined by your specific plan design. Refer to the Appendix for specific details of MSRA and co-expense requirements.
7. **X-rays.** X-rays listed on your plan details in the Appendix are for imaging services at PCP or urgent care facilities only and requires a $25 read fee per view at time of service. Your MSRA will apply to all other X-rays. MRI, CT Scans and other diagnostics must be paid with your MSRA before cost sharing is provided.
8. **Chronic Maintenance**. Chronic maintenance is eligible when a member has chosen a plan with chronic maintenance specifically included and a listing of the maximum number of allowable visits. See ‘Appendix A’ attached hereto.
9. **Emergency Room.** Emergency room services for stabilization or initiation of treatment of a medical emergency condition provided on an outpatient basis at a hospital, clinic, or urgent care facility, including when hospital admission occurs within twenty-three (23) hours of emergency room treatment.
10. **Hospitalization.** Hospital charges for inpatient or outpatient hospital treatment or surgery for a medically diagnosed condition.
11. **Surgical Benefits.** Non life threatening surgical benefits are not available for the first 60 days of membership for Premium plans and all other plans require 6 month wait period. **Please verify eligibility by calling Members Services before receiving any surgical services.**
12. **Prescription Drugs.** The AlieraCare plan includes a service by RX Valet, which includes cost sharing for prescription drugs. See Appendix for details.
13. **Physical Therapy.** Up to six (6) visits per membership year for physical therapy by a licensed physical therapist.
14. **Ambulance.** Emergency land or air ambulance transportation to the nearest medical facility capable of providing the medically necessary care to avoid seriously jeopardizing the sharing member’s life or health.
15. **Naturopathic and/or Alternative Treatments.** Does not included chiropractic services
16. **Prosthetics and their replacement, if medically necessary.** This is not an eligible sharing expense
17. **Medical Costs incurred outside the United States.** Charges for the care and treatment of a medically diagnosed condition when treatment outside the United States is financially beneficial or when traveling or residing outside the United States. Eligibility of such charges are subject to all other provisions of the Guidelines. Medical billing is requested to be submitted in English and converted to U.S. currency.
18. **Smoking Cessation.** Members with preventive coverage who have acknowledged they smoke and made an additional contribution are provided the opportunity to obtain free smoking cessation medication and counseling.

19. **Competitive Sports.** Plan holders who participate in organized and/or sanctioned competitive sports are eligible for $5,000 (max) of sharing per incident at an emergency room, subject to the member-shared responsibility amount.
20. **Maternity.** Maternity medical expenses are only eligible for sharing in certain Plans. Please see the Appendix for your specific plan design. Medical expenses for maternity ending in a delivery by emergency cesarean section that is medically necessary are eligible for sharing up to $8,000 subject to the applicable Member Shared Responsibility Amount. Medical expenses for a newborn arising from complications at the time of delivery, including, but not limited to, premature birth, are treated as a separate incident and limited to $50,000 of eligible sharing, subject to the Member Shared Responsibility Amount. See the Appendix for specific sharing inclusions and limits for your plan choice.

**Medical Expense Incident* is any medically diagnosed condition receiving medical treatment and incurring medical expenses of the same diagnosis. All related medical bills of the same diagnosis comprise the same incident. Such expenses must be submitted for sharing in the manner and form specified by Unity HealthShare[SM]. This may include, but not be limited to, standard industry billing forms (HCFA1500 and/or UB 92) and medical records. Members share these kinds of costs.

LIMITS OF SHARING (MAXIMUM PAYABLE)

Total eligible needs shared from member contributions are limited as defined in this section and as further limited in writing to the individual member.

1. **Lifetime Limits.** $1,000,000: the maximum amount shared for eligible needs over the course of an individual member's lifetime.
2. **Annual Limits.** The maximum amount shared for eligible needs per member per 12 month plan term.
3. **Per Term.** The limit for each term of a sharing plan. Generally, means annually except in the case of short-term cost sharing.
4. **Per Incident.** The occurrence of one particular sickness, illness, or accident.
5. **Cancer Limits when applicable.** Cancer is limited to a maximum per term of $500,000 when applicable
6. **Member Shared Responsibility Amounts (MSRA).** Eligible needs are limited to the amounts in excess of the MSRA, which are applied per individual member per the plan year.
7. **MSRA(s).** The eligible amount that does not qualify for sharing based on the membership type chosen by the member.
8. **Office Visit/Urgent Care.** Office visits, in particular, primary and urgent, have certain limits and inclusions. Please refer to the Appendix for your specific plan.
9. **Non-Affiliated Practitioner.** Services rendered by a non-affiliated practitioner will not be eligible for sharing nor will any amount be applied to your MRSA unless specified differently in the plan details contained herein..
10. **Organ Transplant Limit.** Eligible needs requiring organ transplant may be shared up to a maximum of $150,000 per member. This includes all costs in conjunction with the actual transplant procedure. Needs requiring multiple organ transplants will be considered on a case-by-case basis.
11. **Cost Sharing for Pre-Existing Conditions.** Cost sharing is not available for pre-exising conditions for the first two years of membership.
12. **Overnight Sleep Testing Limit.** All components of a polysomnogram must be completed in one session. A second overnight test will not be eligible for sharing under any circumstance. Overnight sleep testing must be medically necessary and will require pre-authorization (see item 8). Allowed charges will not exceed the Usual, Customary, and Reasonable charges for the area.

Other Resources. Needs do not qualify for sharing to the extent that they are payable by an institutional source such as insurance, VA, Tricare, private grants, or by a liable third party (primary, auto, home insurance, educational, etc.). If the member does not cooperate fully, the need will not be eligible for sharing. The MRSA's are waived up to the maximum MRSA's per membership type only if a liable third party or institutional source pays on the member's behalf. Sharing of monthly contributions for a need that is later paid or found to be payable by an institutional source or a liable third party will automatically allow Unity HealthShare[SM] full rights to recover from the member the amounts shared on their behalf.

See Appendix A below for Additional Sharing Limits by Plan Level

APPENDIX A: PLAN DETAILS

PPO Network	Multiplan | PHCS Specific Services		
PLAN Level	**VALUE[2]**	**PLUS[2]**	**PREMIUM[3]**
Preventative Care	100%	100%	100%
Telemedicine***	100%	100%	100%
Primary Care (PCP)	1 per Year* $20 Consult Fee	3 per Year* $20 Consult Fee	5 per Year* $20 Consult Fee
PCP Chronic Visits	n/a	n/a	Included @ PCP
Urgent Care	n/a	1 per Year* $20 Consult Fee	2 per Year* $20 Consult Fee
Labs & Diagnostics*	Preventive Only	PCP & Urgent Care**	PCP & Urgent Care**
X-rays**	Preventive Only	100%**	100%**
Rx Discount	Included	Included	Included
Pediatrics	Preventive Only	Preventive Only	As Primary Care
OB/GYN	Preventive Only	Preventive Only	As Primary Care
UNITY HealthShare [1,4,5]			
Hospitalization	Included	Included	Included
In-Patient Surgery	Included	Included	Included
Out-Patient Surgery	Included	Included	Included
Specialty Care [8]	n/a	n/a	$75 Consult Fee (100% after MSRA)
Emergency Room [6]	Full MSRA	$500 MSRA	$300 MSRA
Maternity [7]	n/a	n/a	$5,000 Max
Per Incident Maximum Limit	$150,000	$250,000	$500,000
Lifetime Maximum Limit	$1,000,000	$1,000,000	$1,000,000

*Annual Physical unavailable until 9 months after effective date; Lifestyle lab testing not included.

**$25 Read-fee applies for X-rays at urgent care, per X-ray read (rate may vary by city).

***Telemedicine services not available in some states.

1. Pre-existing conditions have a 24-month waiting period
2. Surgical benefits are not available for the first 6 months
3. Surgical benefits are not available for the first 2 months
4. Cancer coverage is provided after 12 months of continuous coverage, if a pre-existing cancer condition did not exist prior to or at the time of application
5. Qualified dependents are under the age of 20. Ages 20-26 can qualify as a dependent, if proven to be a full-time student
6. ER visits are subject to review, and are meant only for life threatening situations. Maximum out-of-pocket is $300 or $500 depending on plan chosen
7. Maternity benefits are not available for the first 10 months
8. The Consult Fee is in addition to the cost of your specialty visit and does not apply toward your annual MSRA

Administrative and Conditional Fees:

- $125 one-time application fee per enrollment
- Add $60 for persons who smoke
- Add Additional $130 per member for additional $500,000 per incident rider

Unity HealthShare plans do not promise to pay medical claims, but follow standard claim eligibility review protocols described in plan.

Products NOT available in: AK, HI, MD, ME, PR, WA, WY; subject to change w/o prior notice.

APPENDIX B: TERMS, CONDITIONS, & SPECIAL CONSIDERATIONS

1. The Welcome Kit you received electronically includes this Member Guide, your Membership Card(s), a Welcome Letter, and important information to activate your membership and any applicable accessory services.
2. Keep your Membership Card with you at all times to present to a provider to confirm eligibility.
3. The ACA is subject to change at any time; Aliera reserves the right to adhere to those changes without notice to the Member.
4. Activate your Plan Membership by following the instructions in this Member Guide.
5. Set up your telemedicine account by following the instructions on the Welcome Letter. Within three weeks of enrollment in Aliera's telemedicine partnering company, Members receive ID Card(s) for the telemedicine service along with instructions on how to utilize the service.
6. Telemedicine operates subject to state regulations and may not be available in certain states.
7. Because more than 80% of primary medical conditions can be resolved by your telemedicine provider, Members must always call the telemedicine provider first to receive medical attention.
8. Telemedicine phone consultations are available 24/7/365, with face-to-face internet consultations available between the hours of 7 a.m. and 9 p.m., Monday – Friday.
9. Telemedicine does not guarantee that a prescription will be written.
10. Telemedicine does not prescribe DEA-controlled substances, non-therapeutic drugs, and certain other drugs which may be harmful because of their potential for abuse. Telemedicine doctors reserve the right to deny care for potential misuse of services.
11. Durable Medical Equipment (DME) – crutches, etc. – is not included in your Plan. Members will be charged for DME at time of service.
12. Aliera cannot guarantee that a provider will accept an Aliera Plan if the Member fails to contact the Aliera Concierge Service first.
13. Member Care Specialists are available to assist you, Monday through Friday, 8 a.m. to 8 p.m. ET at (844) 834-3456. If you call after hours, follow the prompts.
14. At the time of service, payment of $20 (on average) is due for the consultation, and a $25 read fee for X-rays, per X-ray read, if needed. Consult fees vary in different states and may be higher in some cities, including but not limited to, New York City, Chicago, Detroit, Miami, Sacramento, Los Angeles, and San Francisco.
15. Plans may vary from state to state. Providers may be added or removed from Aliera's network at any time without notice.
16. If you become sick while traveling within the U.S., contact your telemedicine provider first. If directed by the telemedicine doctor to seek further treatment, visit www.UnityHealthshare.com and click on "Network" to search by city, state, or zip code for a list of the nearest in-network providers.
17. Not all geographical areas are serviced by Aliera Healthcare. Should a Member visit an emergency room because urgent care facilities are unavailable in the Member's area, Aliera offers a one-time, once-a-year, $105 credit (ex gratia) to the Member to help offset the costs incurred.
18. If an urgent care facility is used for a primary care visit for sick care, an additional fee of $40 will be payable at time of service.
19. Aliera Healthcare telemedicine partners do not replace the Primary Care Provider.
20. Primary Care is defined as "episodic primary care" or "sick care." Members are responsible for paying a consult fee at the time of service; no consult fee is due for preventive service.
21. Most network facilities are able to accommodate both urgent care and primary care needs.
22. Not all PPO providers accept a AlieraCare Plan. While Aliera offers one of the largest PPO networks in the country, some providers may not participate. Provider network online search databases are updated per their own schedule and may be out of synch with your healthcare, specialty care, or hospital provider.

DISCLOSURES

1. Aliera Healthcare, the Aliera Healthcare logo, and other plan or service logos are trademarks of Aliera Healthcare, Inc. and may not be used without written permission.
2. Aliera and Unity programs are NOT insurance. Aliera Healthcare/Unity HealthShare℠ does not guarantee the quality of services or products offered by individual providers. Members may change providers upon 30 days' notice if not satisfied with the medical services provided.
3. Aliera's Healthcare Plans cover services only to Members and dependents on your Plan.
4. Aliera reserves the right to interpret the terms of this membership to determine the level of medical services received hereunder.
5. This membership is issued in consideration of the Member's application and the Member's payment of a monthly fee as provided under these Plans. Omissions and misstatements, or incorrect, incomplete, fraudulent, or

intentional misrepresentation to the assumed risk in your application may void your membership, and services may be denied.

Abbreviations

ACA	Affordable Care Act (Obamacare)	HCSM	Health Care Sharing Ministry
CMS	Center for Medicare and Medicaid Services	MEC	Minimum Essential Coverage
DEA	Drug Enforcement Administration	PCP	Primary Care Provider
DME	Durable Medical Equipment	PPO	Participating Provider Organization
DPCMH	Direct Primary Care Medical Home Plans	UC	Urgent Care

APPENDIX C: LEGAL NOTICES

The following legal notices are the result of discussions by Unity HealthShare(SM) or other healthcare sharing ministries with several state regulators and are part of an effort to ensure that Sharing Members understand that Unity HealthShare[SM] is not an insurance company and that it does not guarantee payment of medical costs. Our role is to enable self-pay patients to help fellow Americans through voluntary financial gifts.

GENERAL LEGAL NOTICE

This program is not an insurance company nor is it offered through an insurance company. This program does not guarantee or promise that your medical bills will be paid or assigned to others for payment. Whether anyone chooses to pay your medical bills will be totally voluntary. As such, this program should never be considered as a substitute for an insurance policy. Whether you receive any payments for medical expenses and whether or not this program continues to operate, you are always liable for any unpaid bills.

STATE SPECIFIC NOTICES

Alabama Code Title 22-6A-2
Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Arizona Statute 20-122
Notice: the organization facilitating the sharing of medical expenses is not an insurance company and the ministry's guidelines and plan of operation are not an insurance policy. Whether anyone chooses to assist you with your medical bills will be completely voluntary because participants are not compelled by law to contribute toward your medical bills. Therefore, participation in the ministry or a subscription to any of its documents should not be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this ministry continues to operate, you are always personally responsible for the payment of your own medical bills.

Arkansas Code 23-60-104.2
Notice: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor plan of operation is an insurance policy. If anyone chooses to assist you with your medical bills, it will be totally voluntary because participants are not compelled by law to contribute toward your medical bills. Participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive a payment for medical expenses or if this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Florida Statute 624.1265
Unity HealthShare[SM] is not an insurance company, and membership is not offered through an insurance company. Unity HealthShare[SM] is not subject to the regulatory requirements or consumer protections of the Florida Insurance Code.

Georgia Statute 33-1-20
Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Idaho Statute 41-121
Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Illinois Statute 215-5/4-Class 1-b
Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation constitute or create an insurance policy. Any assistance you receive with your medical bills will be totally voluntary. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Whether or not you receive any payments for medical expenses and whether or not this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Indiana Code 27-1-2.1
Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor its plan of operation is an insurance policy. Any assistance you receive with your medical bills will be totally voluntary. Neither the organization nor any other participant can be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Whether or not you receive any payments for medical expenses and whether or not this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Kentucky Revised Statute 304.1-120 (7)
Notice: Under Kentucky law, the religious organization facilitating the sharing of medical expenses is not an insurance company, and its guidelines, plan of operation, or any other document of the religious organization do not constitute or create an insurance policy. Participation in the religious

organization or a subscription to any of its documents shall not be considered insurance. Any assistance you receive with your medical bills will be totally voluntary. Neither the organization nor any participant shall be compelled by law to contribute toward your medical bills. Whether or not you receive any payments for medical expenses, and whether or not this organization continues to operate, you shall be personally responsible for the payment of your medical bills.

Louisiana Revised Statute Title 22-318,319
Notice: The ministry facilitating the sharing of medical expenses is not an insurance company. Neither the guidelines nor the plan of operation of the ministry constitutes an insurance policy. Financial assistance for the payment of medical expenses is strictly voluntary. Participation in the ministry or a subscription to any publication issued by the ministry shall not be considered as enrollment in any health insurance plan or as a waiver of your responsibility to pay your medical expenses.

Maine Revised Statute Title 24-A, §704, sub-§3
Notice: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. Participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Maryland Article 48, Section 1-202(4)
Notice: This publication is not issued by an insurance company nor is it offered through an insurance company. It does not guarantee or promise that your medical bills will be published or assigned to others for payment. No other subscriber will be compelled to contribute toward the cost of your medical bills. Therefore, this publication should never be considered a substitute for an insurance policy. This activity is not regulated by the State Insurance Administration, and your liabilities are not covered by the Life and Health Guaranty Fund. Whether or not you receive any payments for medical expenses and whether or not this entity continues to operate, you are always liable for any unpaid bills.

Mississippi Title 83-77-1
Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment of medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Missouri Section 376.1750
Notice: This publication is not an insurance company nor is it offered through an insurance company. Whether anyone chooses to assist you with your medical bills will be totally voluntary, as no other subscriber or member will be compelled to contribute toward your medical bills. As such, this publication should never be considered to be insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always personally responsible for the payment of your own medical bills.

Nebraska Revised Statute Chapter 44-311
IMPORTANT NOTICE. This organization is not an insurance company, and its product should never be considered insurance. If you join this organization instead of purchasing health insurance, you will be considered uninsured. By the terms of this agreement, whether anyone chooses to assist you with your medical bills as a participant of this organization will be totally voluntary, and neither the organization nor any participant can be compelled by law to contribute toward your medical bills. Regardless of whether you receive payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills. This organization is not regulated by the Nebraska Department of Insurance. You should review this organization's guidelines carefully to be sure you understand any limitations that may affect your personal medical and financial needs.

New Hampshire Section 126-V:1
IMPORTANT NOTICE This organization is not an insurance company, and its product should never be considered insurance. If you join this organization instead of purchasing health insurance, you will be considered uninsured. By the terms of this agreement, whether anyone chooses to assist you with your medical bills as a participant of this organization will be totally voluntary, and neither the organization nor any participant can be compelled by law to contribute toward your medical bills. Regardless of whether you receive payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills. This organization is not regulated by the New Hampshire Insurance Department. You should review this organization's guidelines carefully to be sure you understand any limitations that may affect your personal medical and financial needs.

North Carolina Statute 58-49-12
Notice: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor its plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be voluntary. No other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally liable for the payment of your own medical bills.

Pennsylvania 40 Penn. Statute Section 23(b)
Notice: This publication is not an insurance company nor is it offered through an insurance company. This publication does not guarantee or promise that your medical bills will be published or assigned to others for payment. Whether anyone chooses to pay your medical bills will be totally voluntary. As such, this publication should never be considered a substitute for insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always liable for any unpaid bills.

South Dakota Statute Title 58-1-3.3
Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an

insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payments for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Texas Code Title 8, K, 1681.001
Notice: This health care sharing ministry facilitates the sharing of medical expenses and is not an insurance company, and neither its guidelines nor its plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the ministry or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this ministry continues to operate, you are always personally responsible for the payment of your own medical bills. Complaints concerning this health care sharing ministry may be reported to the office of the Texas attorney general.

Virginia Code 38.2-6300-6301
Notice: This publication is not insurance, and is not offered through an insurance company. Whether anyone chooses to assist you with your medical bills will be totally voluntary, as no other member will be compelled by law to contribute toward your medical bills. As such, this publication should never be considered to be insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always personally responsible for the payment of your own medical bills.

Wisconsin Statute 600.01 (1) (b) (9)
ATTENTION: This publication is not issued by an insurance company, nor is it offered through an insurance company. This publication does not guarantee or promise that your medical bills will be published or assigned to others for payment. Whether anyone chooses to pay your medical bills is entirely voluntary. This publication should never be considered a substitute for an insurance policy. Whether or not you receive any payments for medical expenses, and whether or not this publication continues to operate, you are responsible for the payment of your own medical bills.

This is NOT Insurance. This is Healthcare Cost Sharing.

www.unityhealthshare.org

www.alieraheathcare.com

Aliera Healthcare
5901 Peachtree Dunwoody Road, Suite B-200
Atlanta Georgia 30328

T**:** 844-834-3456 | e**Fax:** 1-404-937-6557

KROMODIMEDJO DECLARATION

EXHIBIT 8

Opened: 02/02/2018 - 06:24:02 PM
Email Batch - Batch Member Only

From: info@alierahealth.com
To: taniafunduk@
CC:
BCC:
Subject: Aliera Healthcare - Welcome - ID 673011867
Attachment:

Dear Tania Funduk,

Welcome to your family of healthcare cost sharing. We look forward to serving your healthcare needs. Please read this welcome letter as it contains:

your member portal login information
temporary ID card
other valuable information
As a new member, what are your next steps?

1. Before your plan is effective, become familiar with the benefits of your membership.

Your AlieraCare Quick Guide contains everything you need to know regarding your healthcare plan. For your product Quick Guide, please click here.
The Quick Guide booklet is included in your membership kit which will arrive at your mailing address within 14 business days after your plan□s effective date.
Your temporary card is included below. Please print it and use it until you receive your permanent card in your membership kit.
Access your Member Plan Portal to view and update your personal or payment information. Go to www.alierahealthcare.com and select □Member Resources□ in the navigation menu, and then select □Plan Portal.□ Enter your username and password information:
Username: 673011867
Password: 9wmb2xfeh1

Keep your login information in a safe place for future reference.

2. On or after your effective date (Important: Telemedicine cannot be accessed until on or after your Plan effective date)

Begin by completing your registration with FirstCall Telemedicine. Access FirstCall by visiting www.FirstCallTelemed.com to register your account or call 1-866-920-DOCS (1-866-920-3627) for assistance. Click here for instructions. FirstCall Telemedicine login information is not provided, please complete registration to obtain login information.
Activate your card and verify your membership. Click here and follow the instructions.
Access your Claims Portal for ability to manage your information and get answers to benefit, provider, and claims questions. Go to www.alierahealthcare.com and select □Members□ in the top menu bar on the left and then select □Login□ and click on □New Member Registration□ to access your login information.
3. Using your benefits

Until you receive your permanent ID card, use the temporary card. Your membership is active and you can immediately begin to take advantage of your benefits.
If you have a medical emergency, call 911.
If you feel ill and need assistance, first call FirstCall at 1-866-920-3627 and speak to a medical representative. Remember: activate your plan on or after your effective

date.
For Employer/Group plans, it is required to schedule an appointment with a provider by calling Aliera□s Concierge line at 877-649-7466 for assistance. You can also request an appointment at http://www.alierahealthcare.com/appointments/
For Individual/Family plans, you may elect to schedule appointments with a provider by using the information above, though it is not required.
Member Care

Our friendly and highly experienced staff is ready to help you with all your questions and concerns about your membership. Whether you have a question regarding your services, need assistance, or have a special request contact a Member Services Representative at (844) 834-3456, Monday through Friday from 9:00 AM until 6:00 PM, Eastern Time, or by email at memberservices@alierahealthcare.com.

Order Information

Please review the information below to ensure all details are correct. If you need to make any changes please call Member Care.

Product: AlieraCare Premium - Individual
Order Date: February 2, 2018
Effective Date: March 1, 2018
Amount Paid: $598.10 - February 2, 2018 - Credit Card - SALE - Approved - Payment 1 - Completed - - - [redacted] - 45716B - Products: AlieraCare Premium (17117)

*The entry on your bank or credit card statement for your healthcare payments is □Aliera Healthcare□.

Member Information

ID: 673011867
Name: Tania Funduk
Address: [redacted]
City: Atlanta
State: GA
Zip Code: 30342
Day Phone: (404) [redacted]
Email: taniafunduk[redacted]
Dependents:

Your Temporary ID Card

Until you receive your permanent Member Card in the mail, please print and use the temporary card shown below.

Effective Date: 03/01/2018
Plan ID: AlieraCarePrem
MSRA*: 5000
Primary: Tania Funduk
Primary ID: 673011867
Dependents:

Hospital: YES
In-Patient: YES
Out-Patient: YES

ER: Verify Eligibility
Specialty: Verify Eligibility

855-798-2538 | www.MyRxValet.com

This program is not insurance nor is it offered through an insurance company. This

program does not guarantee or promise that your medical bills will be paid or assigned to others for payment. Whether anyone chooses to pay your medical bills will be totally voluntary. As such, this program should never be considered as a substitute for an insurance policy. Whether you receive any payments for medical expenses and whether or not this program continues to operate, you are always liable for any unpaid bills.
*MSRA = Member Shared Responsibility Amount

Verify eligibility for payment: 844-457-7726

Mail claims forms to:
Aliera Healthcare Unity
P.O. Box 16818
Lubbock, TX 79490-6818
or EDI # : ALH01 | 1-800-252-3684

Member Services: 844-834-3456
Telemedicine: 866-920-3627
Pharmacy: 855-798-2538
Eligibility: 844-457-7726

PROVIDER should verify eligibility before providing treatment or service.

AlieraCare

PCP: $20
Urgent Care: $20
Preventive: $0
X-Ray Read Fee: $25
ER: See Unity

Unity HealthShare

Specialty: $75 Consult fee, Prem only.
ER: Val MSRA | Plus $500 | Prem $300
Surgical Services*: Verify eligibility.
Maternity: $5000 max, Prem only.

Confirm specific services or urgent care at 844-457-7726

Visit multiplan.com or call 800-922-4362 for your PHCS provider.

*Surgical benefits not available for the first 60 to 180 days, depending on AlieraCare Plan. Verify eligibility before receiving any surgical services.

www.alierahealthcare.com | www.unityhealthshare.com

Thank you,

The Aliera Healthcare Team.

Disclosure, Terms and Conditions

To view a copy of the Disclosure Statement and Terms and Conditions, click here.

Aliera Healthcare follows CMS (Centers for Medicare and Medicaid Services) guidelines for recommended preventive care required by the ACA. Aliera also recognizes the U.S. Preventive Services Task Force (USPSTF) for recommended screenings, physicals,

frequency of care, etc. To view your USPSTF A and B Recommendations, click here.

ALIERA Healthcare

Dear Tania Funduk,

Welcome to your family of healthcare cost sharing. We look forward to serving your healthcare needs. Please read this welcome letter as it contains:

- your member portal login information
- temporary ID card
- other valuable information

As a new member, what are your next steps?

1. Become familiar with the benefits of your membership.

- Your AlieraCare Member Guide contains everything you need to know regarding your healthcare plan. For your Member Guide, please click here.
- The Member Guide booklet is included in your membership kit which will arrive at your mailing address within 14 business days *after your plan's effective date.*
- Your temporary card is included below. Please print it and use it until you receive your permanent card in your membership kit.
- Access your Member Portal to view and update your personal or payment information. Go to www.alierahealthcare.com and select Member Login in the navigation menu, and then select Member Portal. *Register your account and keep your login information in a safe place for future reference.*

2. On or After your Effective Date *(**Important**: Telemedicine **cannot** be accessed until **on or after** your Plan effective date)*

- ***Activate and verify your Membership card.*** Click here for instructions.
- ***Access your Claims Portal*** for the ability to manage your information and get answers to provider, claims, and benefit questions. Visit www.alierahealthcare.com and select "Members" in the top menu bar and select "Login". Then click "New Member Registration" to create your login information.
- ***Complete your registration with FirstCall Telemedicine***. Access FirstCall by visiting www.FirstCallTelemed.com to register your account or call 1-866-920-DOCS (1-866-920-3627) for assistance. Click here for instructions. **FirstCall Telemedicine login information is not provided, please complete registration to obtain login information**.

3. Using your benefits

- Until you receive your permanent ID card, use the temporary card. Your membership is active and you can immediately begin to take advantage of your benefits.
- If you have a medical emergency, call 911.
- If you feel ill and need assistance, first call FirstCall at 1-866-920-3627 and speak to a medical representative. ***Remember***: activate your account ***on or after your effective date***.
- **For Employer/Group plans**, it is required to schedule an appointment with a provider by calling Aliera's Concierge line at 877-649-7466 for assistance. You can also request an appointment at http://www.alierahealthcare.com/appointments/
- **For Individual/Family plans**, you may elect to schedule appointments with a provider by using the information above, though it is not required.

Member Care

Our friendly and highly experienced staff is ready to help you with all your questions and concerns about your membership. Whether you have a question regarding your services, need assistance, or have a special request contact a Member Services Representative at (844) 834-3456, Monday through Friday from 8:00 AM until 8:00 PM, Eastern Time, or by email at memberservices@alierahealthcare.com.

Order Information

Please review the information below to ensure all details are correct. If you need to make any changes please call Member Care.

Product: AlieraCare Premium - Individual
Order Date: February 2, 2018
Effective Date: March 1, 2018
Amount Paid: $598.10 - February 2, 2018 - Credit Card - SALE - Approved - Payment 1 - Completed - - - [redacted] - 45716B - Products: AlieraCare Premium (17117)

*The entry on your bank or credit card statement for your healthcare payments is "Aliera Healthcare".

Member Information

ID: 673011867
Name: Tania Funduk
Address: [redacted]
City: Atlanta
State: GA
Zip Code: 30342
Day Phone: (404) [redacted]
Email: taniafunduk@[redacted]
Dependents:

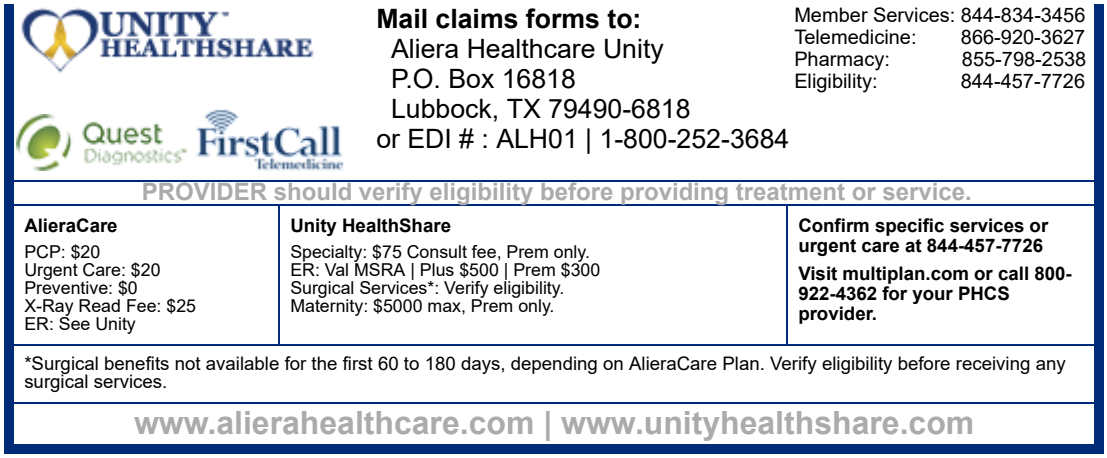
Your Temporary ID Card

Until you receive your permanent Member Card in the mail, please print and use the temporary card shown below.

ALIERACARE / PHCS (Specific Services. Call to Confirm.)		Effective Date: 03/01/2018 Plan ID: AlieraCarePrem MSRA*: 5000
Primary: Tania Funduk Primary ID: 673011867 Dependents:	Hospital: YES In-Patient: YES Out-Patient: YES	ER: Verify Eligibility Specialty: Verify Eligibility
	RX VALET 855-798-2538 | www.MyRxValet.com	

This program is not insurance nor is it offered through an insurance company. This program does not guarantee or promise that your medical bills will be paid or assigned to others for payment. Whether anyone chooses to pay your medical bills will be totally voluntary. As such, this program should never be considered as a substitute for an insurance policy. Whether you receive any payments for medical expenses and whether or not this program continues to operate, you are always liable for any unpaid bills.
***MSRA** = Member Shared Responsibility Amount

Verify eligibility for payment: 844-457-7726



UNITY HEALTHSHARE

Quest Diagnostics FirstCall Telemedicine

Mail claims forms to:
Aliera Healthcare Unity
P.O. Box 16818
Lubbock, TX 79490-6818
or EDI # : ALH01 | 1-800-252-3684

Member Services: 844-834-3456
Telemedicine: 866-920-3627
Pharmacy: 855-798-2538
Eligibility: 844-457-7726

PROVIDER should verify eligibility before providing treatment or service.

AlieraCare	Unity HealthShare	Confirm specific services or urgent care at 844-457-7726 Visit multiplan.com or call 800-922-4362 for your PHCS provider.
PCP: $20 Urgent Care: $20 Preventive: $0 X-Ray Read Fee: $25 ER: See Unity	Specialty: $75 Consult fee, Prem only. ER: Val MSRA | Plus $500 | Prem $300 Surgical Services*: Verify eligibility. Maternity: $5000 max, Prem only.	

*Surgical benefits not available for the first 60 to 180 days, depending on AlieraCare Plan. Verify eligibility before receiving any surgical services.

www.alierahealthcare.com | www.unityhealthshare.com

Thank you,

The Aliera Healthcare Team.

Disclosure, Terms and Conditions

To view a copy of the Disclosure Statement and Terms and Conditions, click here.

Aliera Healthcare follows CMS (Centers for Medicare and Medicaid Services) guidelines for recommended preventive care required by the ACA. Aliera also recognizes the U.S. Preventive Services Task Force (USPSTF) for recommended screenings, physicals, frequency of care, etc. To view your USPSTF A and B Recommendations, click here.

KROMODIMEDJO DECLARATION

EXHIBIT 9

ALIERA Healthcare

Member Cancellation Form

Member Last Name: Funduk
Member First Name: Tania
Date of Birth: [redacted]
( ) Male (X) Female
Member ID Number: 673011867
Today's Date: 7/3/2018
Member Home Address: [redacted]
City: Atlanta
State: Ga
Zip Code: 30342

Plan Cancellation

I am cancelling this membership because the member is:

( ) Deceased
( ) Dissatisfied with service
( ) Purchasing a different plan
( ) Moving out of the area
( ) Terminated from employment
(X) Other, please specify

Out of the country will reactivate when I get back to the Usa

Employers: *Service cancellation is effective on the last date of your billing cycle unless otherwise specified.*

Authorization

Member authorizes the cancellation/change of the abovenamed member's membership.

- Member understands and agrees that the current monthly membership fee payment entitles Member to receive health benefit services until the end of the current term.
- Member understands that as of the end of the membership, Member will not be able to access any of the services offered by Aliera Healthcare.
- Employer (if applicable) understands that all pre-payments beyond the current monthly service period will be pro-rated to the date of cancellation and refunded to the company within ten (10) business days.
- Employer (if applicable) understands that employee may rejoin Aliera Healthcare as an Individual Plan holder at any time under the terms and conditions for registration at that time.

Print Name(s): Tania Funduk
Date: 7/3/2018
Signature(s): DocuSigned by: A07BF17E070F48F...

Please email completed signed form to cancellation@alierahealthcare.com. Forms can be faxed to 478-787-0010.

Additional Information:
I spoke to the customer representatives. I will be traveling out of the country for months and therefore deactivating my health plan until I get back to the states .

DocuSign SECURED

Certificate Of Completion

Envelope Id: 8104A45044164761BBFAA01752CE83C5
Status: Completed
Subject: Please DocuSign: Individual Cancellation Form FILLABLE.pdf Tania Funduk
Source Envelope:
Document Pages: 1
Signatures: 1
Certificate Pages: 5
Initials: 0
AutoNav: Enabled
EnvelopeId Stamping: Enabled
Time Zone: (UTC-05:00) Eastern Time (US & Canada)

Envelope Originator:
Member Accounts Department
5901 Peachtree Dunwoody Road
Suite B-200
Dunwoody, GA 30328
Cancellation@alierahealthcare.com
IP Address: 170.199.233.166

Record Tracking

Status: Original
6/22/2018 11:43:54 AM
Holder: Member Accounts Department
Cancellation@alierahealthcare.com
Location: DocuSign

Signer Events	Signature	Timestamp
Tania Funduk taniafunduk@yahoo.com Security Level: Email, Account Authentication (None)	DocuSigned by: A07BF17E070F48F... Using IP Address: 88.128.80.189 Signed using mobile	Sent: 6/22/2018 11:55:49 AM Viewed: 7/3/2018 9:39:38 AM Signed: 7/3/2018 9:45:38 AM

Electronic Record and Signature Disclosure:
Accepted: 7/3/2018 9:39:38 AM
ID: 79b7ed55-33aa-4225-83f8-2827147514d6

In Person Signer Events	Signature	Timestamp

Editor Delivery Events	Status	Timestamp

Agent Delivery Events	Status	Timestamp

Intermediary Delivery Events	Status	Timestamp

Certified Delivery Events	Status	Timestamp
Member Accounts Department cancellation@alierahealthcare.com Aliera Healthcare Security Level: Email, Account Authentication (None)	VIEWED Using IP Address: 170.199.233.166	Sent: 7/3/2018 9:45:40 AM Viewed: 7/5/2018 4:40:33 PM

Electronic Record and Signature Disclosure:
Not Offered via DocuSign

Carbon Copy Events	Status	Timestamp
Alexander Humphers Raymond@ilifeandhealth.com Security Level: Email, Account Authentication (None)	COPIED	Sent: 7/3/2018 9:45:40 AM

Electronic Record and Signature Disclosure:
Not Offered via DocuSign

Notary Events	Signature	Timestamp

Envelope Summary Events	Status	Timestamps

Envelope Summary Events	Status	Timestamps
Envelope Sent	Hashed/Encrypted	7/3/2018 9:45:40 AM
Certified Delivered	Security Checked	7/5/2018 4:40:33 PM
Completed	Security Checked	7/5/2018 4:40:33 PM

Payment Events	Status	Timestamps

Electronic Record and Signature Disclosure

CONSUMER DISCLOSURE

From time to time, Aliera Healthcare (we, us or Company) may be required by law to provide to you certain written notices or disclosures. Described below are the terms and conditions for providing to you such notices and disclosures electronically through the DocuSign, Inc. (DocuSign) electronic signing system. Please read the information below carefully and thoroughly, and if you can access this information electronically to your satisfaction and agree to these terms and conditions, please confirm your agreement by clicking the 'I agree' button at the bottom of this document.

Getting paper copies

At any time, you may request from us a paper copy of any record provided or made available electronically to you by us. You will have the ability to download and print documents we send to you through the DocuSign system during and immediately after signing session and, if you elect to create a DocuSign signer account, you may access them for a limited period of time (usually 30 days) after such documents are first sent to you. After such time, if you wish for us to send you paper copies of any such documents from our office to you, you will be charged a $0.00 per-page fee. You may request delivery of such paper copies from us by following the procedure described below.

Withdrawing your consent

If you decide to receive notices and disclosures from us electronically, you may at any time change your mind and tell us that thereafter you want to receive required notices and disclosures only in paper format. How you must inform us of your decision to receive future notices and disclosure in paper format and withdraw your consent to receive notices and disclosures electronically is described below.

Consequences of changing your mind

If you elect to receive required notices and disclosures only in paper format, it will slow the speed at which we can complete certain steps in transactions with you and delivering services to you because we will need first to send the required notices or disclosures to you in paper format, and then wait until we receive back from you your acknowledgment of your receipt of such paper notices or disclosures. To indicate to us that you are changing your mind, you must withdraw your consent using the DocuSign 'Withdraw Consent' form on the signing page of a DocuSign envelope instead of signing it. This will indicate to us that you have withdrawn your consent to receive required notices and disclosures electronically from us and you will no longer be able to use the DocuSign system to receive required notices and consents electronically from us or to sign electronically documents from us.

All notices and disclosures will be sent to you electronically

Unless you tell us otherwise in accordance with the procedures described herein, we will provide electronically to you through the DocuSign system all required notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to you during the course of our relationship with you. To reduce the chance of you inadvertently not receiving any notice or disclosure, we prefer to provide all of the required notices and disclosures to you by the same method and to the same address that you have given us. Thus, you can receive all the disclosures and notices electronically or in paper format through the paper mail delivery system. If you do not agree with this process, please let us know as described below. Please also see the paragraph immediately above that describes the consequences of your electing not to receive delivery of the notices and disclosures

electronically from us.

How to contact Aliera Healthcare:

You may contact us to let us know of your changes as to how we may contact you electronically, to request paper copies of certain information from us, and to withdraw your prior consent to receive notices and disclosures electronically as follows:

To contact us by paper mail, please send correspondence to:
Aliera Healthcare
5901 Peachtree Dunwoody Road
Suite B-200
Atlanta, GA 30328

To advise Aliera Healthcare of your new e-mail address

To let us know of a change in your e-mail address where we should send notices and disclosures electronically to you, you must send an email message to us at memberservices@alierahealthcare.com and in the body of such request you must state: your previous e-mail address, your new e-mail address. We do not require any other information from you to change your email address..

In addition, you must notify DocuSign, Inc. to arrange for your new email address to be reflected in your DocuSign account by following the process for changing e-mail in the DocuSign system.

To request paper copies from Aliera Healthcare

To request delivery from us of paper copies of the notices and disclosures previously provided by us to you electronically, you must send us an e-mail to memberservices@alierahealthcare.com and in the body of such request you must state your e-mail address, full name, US Postal address, and telephone number. We will bill you for any fees at that time, if any.

To withdraw your consent with Aliera Healthcare

To inform us that you no longer want to receive future notices and disclosures in electronic format you may:

i. decline to sign a document from within your DocuSign session, and on the subsequent page, select the check-box indicating you wish to withdraw your consent, or you may;
ii. send us an e-mail to whiler@alierahealthcare.com and in the body of such request you must state your e-mail, full name, US Postal Address, and telephone number. We do not need any other information from you to withdraw consent.. The consequences of your withdrawing consent for online documents will be that transactions may take a longer time to process..

Required hardware and software

Operating Systems:	Windows® 2000, Windows® XP, Windows Vista®; Mac OS® X
Browsers:	Final release versions of Internet Explorer® 6.0 or above (Windows only); Mozilla Firefox 2.0 or above (Windows and Mac); Safari™ 3.0 or above (Mac only)
PDF Reader:	Acrobat® or similar software may be required to view and print PDF files
Screen Resolution:	800 x 600 minimum

Enabled Security Settings:	Allow per session cookies

** These minimum requirements are subject to change. If these requirements change, you will be asked to re-accept the disclosure. Pre-release (e.g. beta) versions of operating systems and browsers are not supported.

Acknowledging your access and consent to receive materials electronically

To confirm to us that you can access this information electronically, which will be similar to other electronic notices and disclosures that we will provide to you, please verify that you were able to read this electronic disclosure and that you also were able to print on paper or electronically save this page for your future reference and access or that you were able to e-mail this disclosure and consent to an address where you will be able to print on paper or save it for your future reference and access. Further, if you consent to receiving notices and disclosures exclusively in electronic format on the terms and conditions described above, please let us know by clicking the 'I agree' button below.

By checking the 'I agree' box, I confirm that:

- I can access and read this Electronic CONSENT TO ELECTRONIC RECEIPT OF ELECTRONIC CONSUMER DISCLOSURES document; and
- I can print on paper the disclosure or save or send the disclosure to a place where I can print it, for future reference and access; and
- Until or unless I notify Aliera Healthcare as described above, I consent to receive from exclusively through electronic means all notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to me by Aliera Healthcare during the course of my relationship with you.

KROMODIMEDJO DECLARATION

EXHIBIT 10

Member Information

Name: Tania Funduk
Address: , Atlanta, GA 30342-2473
Phone: (404)
Email: taniafunduk
Date of Birth:
Gender: F

Product Information

Trinity HealthShare Premium

Hospitalization, Emergency Room, In-Patient, and Out-Patient procedures are covered, once the Member Shared Responsibility Amount has been met. The Per Incident limit is $500,000 sharing amount, capped at $1,000,000 lifetime sharing amount.

$141.72 per Month for Individual
$25.00 one-time Application Fee

Questions

MSRA

5000

At the core of what the Healthcare Sharing Ministry does, and how they relate to and engage with one another as a community of people, is a set of common beliefs.

Yes

You understand that this sharing plan has a 24-month waiting period for pre-existing conditions, where pre-existing conditions are defined as conditions that exist at the time of enrollment that have evidenced symptoms, received treatment, and/or medication within the past 24 months.

Yes

You understand that other medical services and emergency surgical services are eligible for cost sharing immediately, but elective surgical services require a 60-day wait period (180-day for AlieraCare Value and AlieraCare Plus) following your effective date.

Yes

You understand that Aliera Healthcare, Inc., and Trinity HealthShare, Inc. have the authority, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to request your medical records to facilitate the payment of medical expenses.

Yes

Check any of these health conditions you have:

Do you use tobacco in any form?

Do you have or ever had Cancer?

If you had Cancer, how long ago?

Do you play in any competitive sports?

Do you drink excessively?

If you drink Alcohol, what is your weekly intake?

Are you pregnant?

AlieraCare Premium

Aliera has combined the Aliera 'MEC' solution with the Trinity HealthShare, Inc. Hospitalization. This two-part offering provides our most robust care and covers catastrophic hospitalization, with the ability to choose from $5,000 to $10,000 MSRA.

$263.19 per Month for Individual
$100.00 one-time Application Fee

Questions

MSRA

5000

At the core of what the Healthcare Sharing Ministry does, and how they relate to and engage with one another as a community of people, is a set of common beliefs.

Yes

You understand that this sharing plan has a 24-month waiting period for pre-existing conditions, where pre-existing conditions are defined as conditions that exist at the time of enrollment that have evidenced symptoms, received treatment, and/or medication within the past 24 months.

Yes

You understand that other medical services and emergency surgical services are eligible for cost sharing immediately, but elective surgical services require a 60-day wait period (180-day for AlieraCare Value and AlieraCare Plus) following your effective date.

Yes

You understand that Aliera Healthcare, Inc., and Trinity HealthShare, Inc. have the authority, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to request your medical records to facilitate the payment of medical expenses.

Yes

Check any of these health conditions you have:

Do you use tobacco in any form?

Do you have or ever had Cancer?

If you had Cancer, how long ago?

Do you play in any competitive sports?

Do you drink excessively?

If you drink Alcohol, what is your weekly intake?

Are you pregnant?

Terms and Conditions for AlieraCare Premium

Aliera Healthcare Plan Disclosures

This is not a contract. This is a voluntary program offered by Aliera Healthcare, in relationship with a HealthCare Sharing Ministry (HCSM) program offered within certain plans. Your membership is with Aliera and cannot be transferred to anyone else. Only you and your enrolled dependents are eligible under the membership.

All Aliera members utilizing any Health Care Sharing Ministry services are required to declare their acknowledgment of the Statement of Beliefs and make an attestation that they are of like mind with the ministry beliefs.

Statement of Beliefs

1. We believe that our personal rights and liberties originate from God and are bestowed on us by God.
2. We believe every individual has a fundamental religious right to worship God in his or her own way.
3. We believe it is our moral and ethical obligation to assist our fellow man when he/she is in need according to our available resources and opportunity.
4. We believe it is our spiritual duty to God and our ethical duty to others to maintain a healthy lifestyle and avoid foods, behaviors or habits that produce sickness or disease to ourselves or others.
5. We believe it is our fundamental right of conscience to direct our own healthcare, in consultation with physicians, family or other valued advisors.

DISCLAIMER

THE MINISTRY IS NOT AN INSURANCE COMPANY AND THE MINISTRY DOES NOT OFFER ANY INSURANCE PRODUCTS OR POLICIES. THE MINISTRY DOES NOT ASSUME ANY RISK FOR YOUR MEDICAL EXPENSES, AND THE MINISTRY MAKES NO PROMISE TO PAY. HEALTH CARE SHARING MINISTRIES ARE NOT GOVERNED BY INSURANCE LAWS.

THE HEALTH CARE SHARING MINISTRY OFFERS VOLUNTARY PARTICIPATION IN ITS HEALTH CARE SHARING MINISTRY. MINISTRY SERVICES ARE ADMINISTERED BY ALIERA HEALTHCARE, INC.

This is not Insurance

A Health Care Sharing Ministry (“HCSM”) is a group of individuals that share a common set of ethical or religious beliefs and share their medical expenses in accordance with those beliefs without regard to the state in which a member resides or is employed.

Services are based on a religious tradition of mutual aid, neighborly assistance, and burden sharing. The ministry does not subsidize self-destructive behaviors and lifestyles but is specifically tailored for individuals who maintain a healthy lifestyle, make responsible choices regarding health and care, and believe in helping others. A Health Care Sharing Ministry program is **NOT** health insurance.

Tax Exemption

YOU SHOULD CONSULT WITH A TAX PROFESSIONAL FOR DETAILS REGARDING YOUR EXEMPTION.

Health Care Sharing Disclosures

Promise to Pay

The ministry does not make a promise to pay or any guarantee of payment of your medical expenses. You will be responsible for the payment of your medical bills. The ministry does not assume your risk. The ministry does not guarantee that your medical expenses will be shared by other members participating in an Aliera Plan that utilize health care sharing services.

Voluntary

Participation in the ministry HCSM is voluntary. Enrollment as an Aliera member and participant of the ministry HCSM is voluntary and the sharing of monetary contributions are also voluntary. Enrollment in the ministry sharing plan is not a contract. You are free to cancel your participation at any time. The ministry requests a Monthly Share Amount, to be collected each month you are enrolled, to facilitate the payment of sharing requests published on behalf of other participants.

Guidelines

The ministry manages its sharing contributions by establishing guidelines that define eligible sharing (“Guidelines”). The Guidelines are not a contract of insurance. They do not constitute an agreement, a promise to pay, or an obligation to share. The Guidelines are intended to ensure that every participant has paid their own medical expenses, as they are financially able, before requesting

others to share with you to assist in paying remaining medical expenses. The Guidelines specify what type of expenses are eligible for sharing requests, so all participants of the ministry HCSM can expect a reasonable and equitable level of sharing requests to be published monthly.

The ministry is authorized to exclude sharing for pre-existing conditions. You are required to fully disclose pre-existing conditions as part of your participation in the HCSM. The ministry reserves the right to exclude sharing eligibility for any pre-existing conditions, whether disclosed at the time of your enrollment or discovered after the effective date of the membership.

AlieraCare Value, Plus, Premium

- Pre-existing conditions have a 24-month waiting period.
- Cancer diagnoses after enrollment have a 12-month continuous membership requirement before sharing is eligible. This means that if you are diagnosed with cancer after you become a member, you are not eligible to request cost sharing of your expenses until you have been an Aliera member for 12 consecutive months.
- There is a maximum limit of $1 million on this Plan.

AlieraCare Bronze, Silver, Gold

- Pre-existing conditions:
  - Bronze: Chronic or recurrent conditions that have evidenced signs/symptoms and/or received treatment and/or medication within the past 24 months are not eligible for sharing during the first 24 months of membership.
  - Silver: During the first two years (24 months) of continuous membership, sharing is available up to $10,000 of total medical expenses incurred for pre-existing conditions per year, after a separate MSRA equal to two times your plan MSRA.
  - Gold: During the first two years (24 months) of continuous membership, sharing is available up to $20,000 of total medical expenses incurred for pre-existing conditions per year, after a separate MSRA equal to two times your plan MSRA.
- Cancer sharing eligibility is available immediately for new occurrences of cancer. Any pre-existing or recurring cancer condition is not eligible for sharing. Cancer sharing will not be available for individuals who have cancer at the time of or five (5) years prior to application.
- There is a maximum limit of $1 million on this Plan.

CarePlus

- Cost sharing does not apply (not eligible) to any illness or accident for which a person has been diagnosed, received medical treatment, been examined, taken medication, or had symptoms within the 24-month period prior to the application date.
- Events covered during the first year of membership become pre-existing condition for the second year, resetting after 24 months.

InterimCare

- Pre-existing conditions have a 24-month waiting period.
- Cancer coverage is provided immediately if a pre-existing cancer condition did not exist within 5 years prior to or at the time of application.
- Charges resulting directly from a pre-existing condition are excluded from cost sharing.
- The pre-existing condition exclusions for Interim Care plans will apply for all members, including those under the age of 19.
- There is a maximum limit of $1 million on this Plan.

Dates of Service

The ministry reserves the right to make updates to its Guidelines at any time. The Guidelines in effect at the time of service will supersede all previous versions of the Guidelines. Members will be notified in advance of updates.

Membership Dues and Fees

- An administrative fee of $25.00 is assigned to administrative costs from each Monthly Share Amount regardless of family size, as provided in the Guidelines. Collection of this fee will begin in the third membership month and will be collected monthly for each following month.

Assigned Need

The ministry will assign a recommended cost sharing amount to the membership each month ("Monthly Share Amount"). By submitting the Monthly Share Amount, you instruct the ministry to assign your contribution as prescribed by the Guidelines.

Up to 40% of your member contribution goes towards the administration of this plan and other general overhead costs to successfully carry out the duties of administering these services.

Membership Guidelines Details

Each Aliera member is responsible for reviewing the HCSM Guidelines provided at the time of enrollment, and to abide by the terms of the Guidelines. It is your responsibility to understand which of your medical expenses are eligible for cost sharing, and which medical expenses are NOT eligible for cost sharing. Members are also provided with a toll-free number to contact Member Services with any questions they have. It is recommended that members call Member Services with any questions regarding eligibility prior to seeking medical services.

Authorizations

- I authorize Aliera Healthcare, Inc. ("Aliera"), on behalf of the ministry, to collect the Monthly Share Amount as a recurring monthly transaction.
- I authorize my first Monthly Share Amount to be processed immediately upon completion of my enrollment.
- I understand that the enrollment fee will be refunded automatically if all individuals on my enrollment form fail to attest to the ministry Statement of Beliefs or if I withdraw my enrollment prior to my membership effective date.
- I understand that the enrollment fee will not be refunded if, in the course of enrolling, I fail to respond to written or verbal inquiries from the ministry or Aliera (as the ministry's administrator) for more than sixty days.
- I understand that the ministry offers voluntary participation in the health care sharing ministry, and I understand that Aliera owns and administers memberships on behalf of the ministry.
- I understand both Aliera and the HCSM have the authorization to contact providers to request the release of medical records on behalf of the member.

Acknowledgment

- I affirm that the name and personal information provided on this form are true and correct.
- I affirm that I understand and accept the disclosures presented above.

Refunds

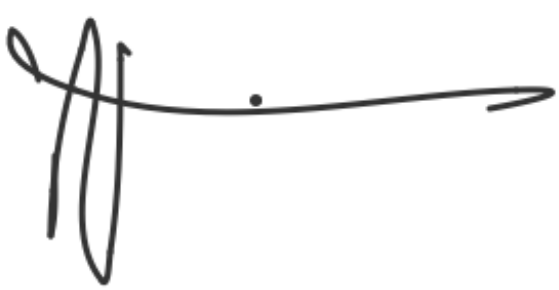
You are entitled to a full refund, including the one-time enrollment fee, if you cancel your membership within 10 days of the effective date of the membership. You must cancel within 10 days of your effective date to be eligible for a full refund.
If you are canceling your membership after the first 30 days of your membership, you may be eligible for a refund of the most recently paid membership period, but only if you cancel within 10 days of your scheduled billing date. Any cancellation requests processed more than 10 days from the scheduled billing date will NOT receive a refund, and the membership will remain active until the end of that billing period.
Refunds will be processed as a credit to the same card or account provided for billing. Requests involving refunds payable by check may be delayed up to 30 business days.

Payment Method

Type: Credit Card
Name: Tania Funduk
Number: [redacted]
Expiration: [redacted]

Electronic Signature

By electronically acknowledging this authorization, I acknowledge that I have read and agree to the terms and conditions set forth in this agreement.



Name: Tania Funduk
Date: November 1, 2018 at 2:42:55 PM
IP Address:
System:

KROMODIMEDJO DECLARATION

EXHIBIT 11

ALIERACARE™

Your Aliera Family of Unity HealthShare
Cost Sharing Plans

MEMBER GUIDE & SHARING NEEDS

In partnership with

ALIERA™ Healthcare

UNITY™ HEALTHSHARE

Contents

MEMBER GUIDE

WELCOME!

Welcome to your AlieraCare plan! Thank you for becoming a Unity HealthShare member. We are committed to providing you and your family with unparalleled service and care at an affordable cost, and we pledge to keep our focus on what's most important – your overall health and wellness.

Please take a few minutes to review the information in this guide. The more informed you are, the easier it will be to get the care you need when you need it the most. Your membership card(s) and this booklet provide important information about your Plan, as well as the steps you need to take to access healthcare at one of the thousands of participating network provider locations. Your welcome information, Member Portal access and temporary member cards are contained in your Welcome Email: please print it and save a copy for reference.

If you have any questions about your Plan, activating your Membership Card, setting up your telemedicine account, pharmacy benefit, or accessing a healthcare provider, please contact a Member Care Specialist for assistance, Monday through Friday, 8 a.m. to 8 p.m. ET at (844) 834-3456.

Member Portal
Username and password credentials are needed to enter the Member's portal to update payment or personal information. Visit www.AlieraHealthcare.com and click the Member Login tab. Your user name and password are on the Welcome Email sent at the time of initial enrollment. Member Services can send you a copy of this email following confirmation of identity.

Contact Information
For general information, account management, monthly contribution, or medical needs, please contact us.

Phone: 844-834-3456

eFax: 1-404-937-6557 (+1 required for eFax)

Email: memberservices@alierahealthcare.com | memberservices@unityhealthshare.com

Online: www.alierahealthcare.com | www.unityhealthshare.com

Mail: 5901 Peachtree Dunwoody Road, Suite B-200, Atlanta Georgia 30328

Disclaimer
Unity HealthShare[SM] is a faith-based medical need sharing membership. Medical needs are only shared by the members according to the membership guidelines. Our members agree to the Statement of Beliefs and voluntarily submit monthly contributions into a cost sharing account with Unity HealthShare, acting as a neutral clearing house between members. Organizations like ours have been operating successfully for years. We are including the following caveat for all to consider:

> *This publication or membership is not issued by an insurance company, nor is it offered through an insurance company. This publication or the membership does not guarantee or promise that your eligible medical needs will be shared by the membership. This publication or the membership should never be considered as a substitute for an insurance policy. If the publication or the membership is unable to share in all or part of your eligible medical needs, or whether or not this membership continues to operate, you will remain financially liable for any and all unpaid medical needs.*
>
> *This is not a legally binding agreement to reimburse any member for medical needs a member may incur, but is instead, an opportunity for members to care for one another in a time of need and to present their medical needs to other members as outlined in the membership guidelines. The financial assistance members receive will come from other members' monthly contributions that are placed in a sharing account, not from Unity HealthShare.*

PLAN SERVICES AND MEMBERSHIP AT A GLANCE

Aliera Healthcare services and Unity HealthShare cost sharing combine to create a full range of services and benefits, summarized below:

ALIERA Healthcare

PREVENTIVE CARE

As part of our solution, the plans cover medical services recommended by the USPSTF and outlined in the ACA for preventive care. There is zero out of pocket expense and no deductible to meet for any scheduled preventive care service or routine in-network check-up, pap smear, flu shot and more. It's easier to stay healthy with regular preventive care.

EPISODIC PRIMARY CARE

Primary care is at the core of an Aliera Plan, and we consider it a key step in getting and staying healthy. Our model is based on an innovative approach to care that is truly patient-centered, combining excellent service with a modern approach. This includes medical care needs such as primary care, office visits, basic eye and hearing exams, flu shots, infections, etc.

CHRONIC CARE

With a AlieraCare Premium Plan, you receive chronic care management for conditions such as diabetes, asthma, blood pressure, cardiac conditions, etc. Members' primary care assigned physicians also perform any outpatient designated services.

LABS & DIAGNOSTICS

All PCP and Urgent Care labs are included in your monthly membership. Your membership includes over 180 different lab tests to ensure the medical care you need is covered.

TELEMEDICINE

Whether sick, at work or in bed all day, a doctor is only a phone call away. Talk to a doctor on your phone or video chat and have your problem diagnosed, medicine prescribed, or if necessary, be further instructed.

With 24/7/365 access to a doctor, staying healthy has never been simpler. Reap the benefit of innovative healthcare.

PRESCRIPTION DRUG PROGRAM

The AlieraCare prescription savings program delivers significant discounts for a variety of drugs (depending on prescription), saving members an average of 55% on prescription drug purchases.

URGENT CARE

For those medical situations that can't wait or are more complex than primary care services, AlieraCare Plans offer access to urgent care facilities at hundreds of medical centers throughout the United States.

UNITY HEALTHSHARE

MEMBERSHIP

Unity HealthShare(sm) is a health care sharing ministry (HCSM) which acts as an organizational clearing house to administer sharing of health care needs for qualifying members. The Unity HealthShare membership is NOT health insurance. The membership is based on a religious tradition of mutual aid, neighborly assistance, and burden sharing. The membership does not subsidize self-destructive behaviors and lifestyles, but is specifically tailored for individuals who maintain a healthy lifestyle, make responsible choices in regards to health and care, and believe in helping others. Because Unity HealthShare is a religious organization, members are required to agree with the organizations Statement of Beliefs; see Part II of this guide for the full description and membership details.

HOSPITALIZATION

Hospitalization is covered, once the Member Shared Responsibility Amount has been met, under all the individual plans. The Per incident limit for coverage ranges from $150,000 to $1,000,000.

SURGERY

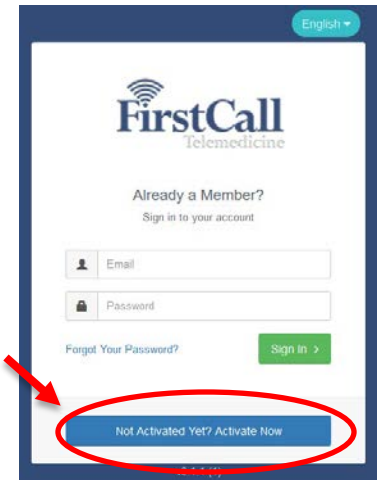
Both in-patient and out-patient procedures are covered, once the Member Shared Responsibility Amount has been met, under all individual plans. The Per incident limit for coverage ranges from $150,000 to $1,000,000.

GETTING STARTED

What does it mean? Many of the terms used in describing health cost sharing may be unfamiliar to those new to the programs and plans provided by Aliera and Unity HealthShare. Please refer to the Definition of Terms section for a quick and easy understanding of terms used in this guide and other plan documents.

1. **Activate Your Membership**
   Visit www.alierahealthcare.com to securely enter your information. Under Member Resources menu, click *Activation* and follow the instructions. If you require assistance, contact a Member Care Specialist toll-free at (844) 834-3456 or email memberservices@alierahealthcare.com.

2. **Set Up Your Telemedicine Account**
   Follow the steps below to set up your telemedicine account. If you have not activated your Membership Card, or if your Membership fees are not paid up to date, you are not eligible to set up your telemedicine account.



Set up your account (Primary Member)
Visit www.firstcalltelemed.com, Click “Set up account.” Follow the online instructions and provide the required information, including your medical history.

Set up minor dependents (17 years or younger)
Log in to your account and click “My Family” on the top menu. Follow the online instructions to provide the necessary information and complete your dependent’s medical history.

Set up adult dependents (18 – 26 years)
Adult dependents must set up their own account. Visit the website and click “Set up account.” Follow the online instructions to provide the required information and to complete your medical history.

3. **Review Your Benefits**
   This guide contains the information you need to understand each benefit available with your Plan. Keep your Member Card with you at all times; the contact number for your telemedicine provider is printed on your card. You must always contact your telemedicine provider before seeking medical attention.

PART I

How to Use Your Membership

THE TELEMEDICINE PROGRAM

More than 80% of primary medical conditions can be resolved by your telemedicine provider. Members are required to contact their telemedicine provider first for quick, convenient medical assistance. The contact information for your telemedicine provider is found on your member card from the telemedicine provider.

Benefits of the Telemedicine Program

- At home, at work, or while traveling in the US, speak to a telemedicine doctor from anywhere, anytime, on the go!
- 24/7 access to a doctor via face-to-face internet consultation or by phone is available for you and dependents on your Plan.
- Speak with the next available doctor or schedule an appointment for a more convenient time.
- Telemedicine doctors typically respond within 15 minutes of your call.
- Save time and money by avoiding expensive emergency room visits, waiting for an appointment, or driving to a local facility.
- Telemedicine consultations are free for you and dependents on your Plan.
- Telemedicine providers can treat conditions such as:
  - ► Cold and flu symptoms
  - ► Bronchitis
  - ► Allergies
  - ► Poison ivy
  - ► Pink eye
  - ► Urinary tract infections
  - ► Respiratory infections
  - ► Sinus problems
  - ► Ear infections; and more!

Antibiotics are not always the answer to treat a medical condition. Doctors may choose not to prescribe antibiotics for viral illnesses such as common colds, sore throats, coughs, sinus infections, and the flu.

If the telemedicine doctor recommends that you see your PCP or visit an urgent care facility, contact Aliera's Concierge Service, and a member care specialist will be happy to assit you with scheduling an appointment.

CONCIERGE SERVICE & CARE COORDINATION

Our care coordination service is designed to help members navigate the healthcare system effectively and efficiently. Aliera's Concierge Service smoothly coordinates your medical care. Members are encouraged to contact Aliera's Concierge Service for scheduling appointments for all services.

How to Use the Concierge Service

1. Always call your telemedicine provider first when you have a medical issue. The contact information for your telemedicine provider is found on your membership card from the telemedicine provider.
2. If the telemedicine provider is unable to resolve your medical issue and recommends further treatment, the Member may contact Aliera's Concierge Service at (844) 834-3456 for coordination of your care and scheduling of appointments with doctors and urgent care facilities. Members are not required to use the concierge but it is available for your convenience.
3. Be sure to have your Membership number available when contacting Aliera's Concierge Service. Membership numbers are located on the front of your member card.
4. When you arrive for your appointment at the provider's location, please present your Membership Card and one photo ID. The front desk admin will check your eligibility status. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the provider.
5. If your PCP makes a referral to a specialist or another provider, contact Aliera's Concierge Service at (844) 834-3456 to schedule and coordinate your visit. Emergency room, hospitalization, and specialty services are described under Part II (HCSM) and Part III (Eligible Needs and Limitations) of this document.

PREVENTIVE CARE

It's easier to stay healthy when you have regular preventive care. Members have no out-of-pocket expenses for preventive services, which include, but are not limited to, routine in-network checkups, pap smears, flu shots and more.

How to Use Preventive Care Services

1. Download the Preventive Healthcare Guidebook from the link found in your Welcome email or visit us online at www.AlieraHealthcare.com. or www.unityhealthshare.com
2. Members do not need to call their telemedicine provider to schedule preventive care. However, all preventive care appointments must be scheduled through Aliera's Concierge Service at (844) 834-3456.
3. Aliera cannot guarantee that a provider will accept an Aliera/Unity Plan if the Member fails to contact our Concierge Service first. Please allow 7–10 days for preventive care appointments.
4. Immunization, imaging, and radiological services are provided at select network centers in each state. Call Aliera's Concierge Service to schedule an appointment. Please allow up to three weeks for an appointment.
5. Upon arrival at a PCP, please present your Membership Card and one photo ID. The front desk admin will check your eligibility status. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the provider.
6. Preventive health services must be appropriate for the covered person and follow the guidelines below:
    - **a)** In general – those of the U.S. Preventive Services Task Force that have an A or B rating.
    - **b)** For immunizations – those of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
    - **c)** For preventive care and screenings for children and adolescents – those of the Health Resources and Services Administration.
    - **d)** For preventive care and screenings for women – those of the Health Resources and Services Administration that are not included in section (A) of the U.S. Preventive Services Task Force schedule.

LABS AND DIAGNOSTICS

Aliera and Unity Members have access to lab work in the convenience of their provider's office or at any of the 2,000+ Quest lab network locations nationwide.

- Convenience: Aliera and Unity partner with **Quest Diagnostics** nationwide; you can be tested in a doctor's office or at any of the 2,000+ testing centers across the US.
- Expertise: With more than 40,000 employees, including nearly 900 MDs, PhDs, and other specialists, Quest assures the highest quality medical services.
- Services: Quest offers more than 3,000 tests, from basic to the most complex, including many you can't get elsewhere.
- Innovation: Quest introduced more than 100 tests – many of which were the first available on the market to help detect numerous diseases.

How to Access MyQuest

MyQuest allows you to schedule appointments 24/7 for testing, access your test results, and track your health conditions using your computer or smartphone.

1. To set up your MyQuest account, visit www.myquest.questdiagnostics.com. Click "Sign Up," then "Register Now."
2. Follow the online instructions and provide your information to complete the patient registration.
3. After setting up your MyQuest account, you can get Advanced Access, which allows you to see your test results as far back as 2010, including graphic representations of how your health is trending over time.
4. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the services provided by Quest.
5. Visit www.Alierahealthcare.com to locate your nearest Quest facility. Click the Network tab and select "Lab Test Locations" from the drop-down menu.

URGENT CARE

Your membership raises the standard of healthcare by putting individuals first, treating them with clinical excellence, and focusing on their well-being. Members can access services from hundreds of urgent care network facilities throughout the United States.

- Plans vary, and can provide up to two (2) visits, where consult fee may apply.
- See appendix for your specific plan details.
- X-rays are included, and subject to a read fee, per X-ray read.

How to Use the Urgent Care Service

1. Call 911 if your emergency is life threatening; otherwise, please contact your telemedicine provider first via telephone or a scheduled face-to-face internet conference. Your provider will determine if your medical condition can be resolved without visiting a local urgent care facility.
2. If your medical issue cannot be resolved after your free consultation with a telemedicine doctor, call Aliera's Concierge Service at (844) 834-3456. A coordinator will call the urgent care facility ahead of your arrival to manage a smooth check-in.
1. After 6 p.m., contact an after-hours Member Care Specialist at (844) 834-3456. If you are unable to connect with the Concierge Service, please go to the nearest in-network urgent care facility. To locate a facility, visit www.AlieraHealthcare.com, click "Network" to find the nearest urgent care facility.
3. Upon arrival at an urgent care facility, present your Membership Card and one photo ID. The front desk admin will check your eligibility status. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the provider.
4. At time of service, payment of $20 (on average) is due for the consultation, and a $25 read fee for X-rays if needed may be due. Costs may be higher depending on your state and provider.

If Urgent Care Services are Unavailable

If an urgent care facility in the network is unavailable to a Member requiring immediate urgent care, please adhere to the following procedure:

2. If unable to connect with the Concierge Service, the Member must go to the nearest in-network urgent care facility. Visit www.AlieraHealthcare.com. Click "Network" to find the nearest urgent care facility under MultiPlan.
3. If the nearest in-network facility is more than 20 miles away from the Member, is closed (after 6:00 p.m.), or is no longer in business, the Member should seek out the nearest urgent care facility or hospital emergency room to receive urgent medical attention.
4. Unity HealthShare products are not health insurance plans and Aliera nor Unity is responsible for payment to out-of-network urgent care or hospital emergency room facilities. The Member is solely responsible for such urgent care medical payments. Aliera and or Unity maintains an allotment fund designed to provide a Member with supplemental payment assistance (ex gratia) in the amount of $105.00 to offset the cost incurred at an out-of-network urgent care or hospital emergency room facility. This monetary assistance is limited to one visit per year, per Member. Payment is made directly to the Member after confirmation of submitted proof of urgent care necessity and unavailability of an in-network provider.

PRIMARY CARE FOR SICK CARE

In addition to our urgent care services, many of our plans offer Members under the age of 65 episodic primary care or sick care.

- Plans with annual PCP visits include one (1), three (3), or five (5) visits, each with consult fee ranging from $20 to $40 in certain markets.
- For convenience, some clinics are open evenings and weekends.

How to Use Primary Care Service for Sick Care

1. Contact your telemedicine provider to speak with a US board-certified doctor via telephone or a scheduled face-to-face internet conference.
2. The telemedicine doctor may be able to resolve your medical issue and prescribe medication if needed. More than 80% of primary medical conditions can be resolved by your telemedicine provider.
3. If your medical issue cannot be resolved after your free consultation with the telemedicine doctor, you can call Aliera's Concierge Service at (844) 834-3456 to schedule an appointment with your local provider if you wish. You may also make your own appointment.
4. Upon arrival at a clinic, present your Membership Card and one photo ID. The front desk admin will check your eligibility status before you can see a provider. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the provider.
5. At the time of service, a payment of $20 (on average) is due for the consultation, and a $25 read fee for X-rays, per X-ray read, if needed. Costs may be higher depending on your state and provider.

PRIMARY CARE FOR SICK CARE AND CHRONIC MAINTENANCE

Plan Members are eligible to visit an in-network physician for an annual physical exam, chronic maintenance, and preventive services.

- The Member is eligible for an annual physical exam after nine (9) months of continuous coverage. All other preventive care as directed by a physician is available immediately.
- For convenience, some clinics are open evenings and weekends.

How to Use Primary Care Service for Sick and Chronic Care

1. Contact your telemedicine provider to speak with a US board-certified doctor via telephone or a scheduled face-to-face internet conference.
2. The telemedicine doctor may be able to resolve your medical issue and prescribe medication if needed. More than 80% of primary medical conditions can be resolved by your telemedicine provider.
3. If your medical issue cannot be resolved after your free consultation with the telemedicine doctor, you can call Aliera's Concierge Service at (844) 834-3456 to schedule an appointment with your local provider if you wish. You may make your own appointment.
4. Upon arrival at a clinic, present your Membership Card and one photo ID. The front desk admin will check your eligibility status before you can see a provider. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the provider.
5. At the time of service, a payment of $20 (on average) is due for the consultation, and a $25 read fee for X-rays, per X-ray read, if needed. Costs may be higher depending on your state and provider.

SPECIALTY CARE

Unity healthshare members are required to obtain referrals to visit a specialist, except for women in need of gynacological care for routine medical needs.

HOSPITALIZATION

Your hospitalization cost sharing is provided to you in an effort to alleviate the stress and strain during times of crisis or medical needs.

1. Members are required to pre-authorize all hospitalization services and visits unless it is an obvious medical emergency. Please see pre-authorization section for instructions
2. You are responsible for your MSRA first before cost sharing is available to reimburse the providers and hospital facilities.
3. Several plans allow for fixed cost sharing in the emergency room. Please see Appendix A for your exact plan details.

PPO NETWORK

With a growing nationwide PPO network of more than 1,000,000 healthcare professionals and more than 6,000 facilities, Multiplan PHCS network offers Plan Members a range of quality choices to help them stay healthy.

- Search for providers by distance, cost efficiency, and specialty.
- While some Plans do not cover specialty services, Aliera's Concierge Service in unison with Unity HealthShare℠ will help you find doctors in 22 different medical specialties who meet certain cost and quality measures. See specific Plan details for your Plan's Specialty Services coverage.

Find a Network Healthcare Professional

- Visit www.Multiplan.com and search for a provider by zip code, city, county, state, or other search criteria.

Call Aliera Healthcare at (844) 834-3456 or Unity Healthshare at (800)-847-9794. Select the Provider Coordination Department and a care coordinator will help you navigate the healthcare process effectively and efficiently.

PART II

How Your Healthcare Cost Sharing Ministry (HCSM) Works

MEMBERSHIP OVERVIEW

Unity HealthShare[SM] is a clearing house that administers voluntary sharing of healthcare needs for qualifying members. The membership is based on a tradition of mutual aid, neighborly assistance, and burden sharing. The membership does not subsidize self-destructive behaviors and lifestyles, but is specifically tailored for individuals who maintain a healthy lifestyle, make responsible choices in regards to health and care, and believe in helping others. The Unity HealthShare[SM] membership is not health insurance.

Guidelines Purpose and Use

The HCSM guidelines are provided as an outline for eligible needs in which contributions are shared in accordance with the membership's escrow instructions. They are not for the purpose of describing to potential contributors the amount that will be shared on their behalf and do not create a legally enforceable right on the part of any contributor. Neither these guidelines nor any other arrangement between contributors and Unity HealthShare[SM] creates any rights for any contributor as a reciprocal beneficiary, as a third-party beneficiary, or otherwise.

The edition of the guidelines in effect on the date of medical services supersedes all previous editions of the guidelines and any other communication, written or verbal. With written notice to the general membership, the guidelines may change at any time based on the preferences of the membership and on the decisions, recommendations, and approval of the Board of Trustees.

An exception to a specific provision only modifies that provision and does not supersede or void any other provisions.

Individuals Helping Individuals

Contributors participating in the membership help individuals with their medical needs. Unity HealthShare[SM] facilitates in this assistance and acts as an independent and neutral escrow agent, dispersing monthly contributions as described in the membership escrow instructions and guidelines.

MEMBERSHIP QUALIFICATIONS

To become and remain a member of Unity HealthShare[SM], a person must meet the following criteria:

Religious Beliefs and Standards. The person must have a belief of helping others and/or maintaining a healthy lifestyle as outlined in the Statement of Beliefs contained in the membership application. If at any time during participation in the membership, a violation of the Statement of Beliefs is found, the individual not honoring this standard may be subject to removal from participation in the membership.

Medical History. The person must meet the criteria to be qualified for a membership on his/her application date, based on the criteria set forth in this guidebook and the membership application.

If, at any time, it is discovered that a member did not submit a complete and accurate medical history on the membership application, the criteria set forth in the Membership Eligibility Manual on his/her application date will be applied, and could result in either a retroactive membership limitation or a retroactive denial to his/her effective date of membership.

Members may apply to have a membership limitation removed by providing medical evidence that they qualify for such removal according to the criteria set forth in the Membership Eligibility Manual. Membership limitations and denials can be applied retroactively but cannot be removed retroactively.

Application, Acceptance, and Effective Date. The person must submit a membership application and be accepted into the membership by meeting the criteria of the Member Eligibility Manual. The membership begins on a date specified by Unity HealthShare[SM] in writing to the member.

Dependent(s). A dependent may participate under a combined membership with the head of household.

A dependent who wishes to continue participating in the membership but who no longer qualifies under a combined membership must apply and qualify for a membership based on the criteria set forth in the Membership Eligibility Manual.

Under a combined membership, the head of household is responsible for ensuring that everyone participating under the combined membership meets and complies with the Statement of Beliefs and all guideline provisions.

Financial Participation. Monthly contributions are requested to be received by the 1st or 15th of each month depending on the member's effective date. If the monthly contribution is not received within 5 days of the due date, an administrative

fee will be assessed to track, receive, and post the monthly contribution. If the monthly contribution is not received by the end of the month, a membership will become inactive as of the last day of the month in which a monthly contribution was received.

Any member who has a membership that has become inactive will be able to reapply for membership under the terms outlined to them in writing by Unity HealthShare[SM]. Any member who submits a monthly contribution in such a manner as to have a membership become inactive three times will not be able to reapply for membership.

Needs occurring after a member's inactive date and before they reapply are not eligible for sharing.

Administrative Costs. The fees for the first two months of membership are applied as an administrative fee. Beginning the third month of membership and each month following, a fee of $25 is assigned to administrative costs from each contribution amount regardless of family size. A single, couple, or family membership all contribute $25 from their monthly contribution for administration. In addition, the annual membership dues are also utilized by Unity HealthShare[SM] to defray administrative costs.

When Available Shares are less than Eligible Needs. In any given month, the available suggested share amounts may or may not meet the eligible needs submitted for sharing. If a member's eligible bills exceed the available shares to meet those needs, the following actions may be taken:

1. A pro-rata sharing of eligible needs may be initiated, whereby the members share a percentage of eligible medical bills within that month and hold back the balance of those needs to be shared the following month.
2. If the suggested share amount is not adequate to meet the eligible needs submitted for sharing over a 60-day period, then the suggested share amount may be increased in sufficient proportion to satisfy the eligible needs. This action may be undertaken temporarily or on an ongoing basis.

Other Criteria. Children under the age of 18 may not qualify for membership. Non-U.S. citizens may qualify for membership as determined by Unity HealthShare[SM] on a case-by-case basis.

MONTHLY CONTRIBUTIONS

Monthly contributions are voluntary contributions or gifts that are non-refundable. As a non-insurance membership, neither Unity HealthShare[SM] nor the membership are liable for any part of an individual's medical need. All contributors are responsible for their own medical needs. Although monthly contributions are voluntary contributions or gifts, there are administrative costs associated with monitoring the receipt and disbursement of such contributions or gifts. Therefore, declined credit cards, returned ACH payments, or any contribution received after the 1st or 15th of each month will incur an administrative fee.

Members wishing to change to a membership type other than that which they are currently participating may, at the discretion of Unity HealthShare[SM], be required to submit a new signed and dated membership application for review. Membership type changes can only become effective on the first of the month after the new membership application has been approved.

Contributors wishing to discontinue participation in the membership must submit the request in writing by the 20th day of the month before which the contributions will cease. The request should contain the reason why the contributor is discontinuing participation in the membership. Should the contributor fail to follow these guidelines as they pertain to discontinuing their participation in the membership and later wishes to reinstate their membership, unsubmitted contributions from the prior participation must be submitted with a new application.

A member is not eligible for cost sharing when a member:

a) has paid a monthly contribution and then cancels within 30 days of receiving medical attention, except within the last 90 days of the membership term;

b) receives care within the first 60 days of the plan and cancels his membership within 30 days of receiving medical care;

c) receives or requires surgery within the first 60 days of becoming a member except in the case of an accident.

EARLY VOLUNTARY TERMINATION

Members of the Unity HealthShare may terminate their membership at any time, with 30 days prior notice. Unity HealthShare plans are not a substitute for "short term medical plans". Medical expenses incurred during the term of the membership and followed by early voluntary termination within 90 days of incurring medical expenses, will be reviewed

and may not be eligible for cost sharing, where the early termination was not as a direct result of affordability issues with the health sharing program.

STATEMENT OF BELIEFS

At the core of what we do, and how we relate to and engage with one another as a community of people, is a set of common beliefs. Our Statement of Shared Beliefs is as follows:

1. We believe that our personal rights and liberties originate from God and are bestowed on us by God.
2. We believe every individual has a fundamental religious right to worship God in his or her own way.
3. We believe it is our moral and ethical obligation to assist our fellow man when they are in need per our available resources and opportunity.
4. We believe it is our spiritual duty to God and our ethical duty to others to maintain a healthy lifestyle and avoid foods, behaviors, or habits that produce sickness or disease to ourselves or others.
5. We believe it is our fundamental right of conscience to direct our own healthcare in consultation with physicians, family, or other valued advisors.

DEFINITIONS OF TERMS

Terms used throughout the Member Guide and other documents are defined as follows:

Affiliated Practitioner. Medical care professionals or facilities that are under contract with a network of providers with whom Unity HealthShare[SM] works. Affiliated providers are those that participate in the PHCS network. A list of providers can be found at http://www.multiplan.com.

Application Date. The date Unity HealthShare[SM] receives a complete membership application.

Combined Membership. Two or more family members residing in the same household.

Contributor. Person named as head of household under the membership.

Dependent. The head of household's spouse or unmarried child(ren) under the age of 26 who are the head of household's dependent by birth, legal adoption, or marriage who is participating under the same combined membership.

Eligible. Medical needs that qualify for voluntary sharing of contributions from escrowed funds, subject to the sharing limits.

Escrow Instructions. Instructions contained on the membership application outlining the order in which voluntary monthly contributions may be shared by Unity HealthShare[SM].

Guidelines. Provided as an outline for eligible medical needs in which contributions are shared in accordance with the membership's escrow instructions.

Head of Household. Contributor participating by himself for herself; or the husband or father that participates in the membership; or the wife or mother if the husband does not participate in the membership.

Licensed Medical Physician. An individual engaged in providing medical care and who has received state license approval as a practicing Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

Medically Necessary. A service, procedure, or medication necessary to restore or maintain physical function and is provided in the most cost-effective setting consistent with the member's condition. Services or care administered as a precaution against an illness or condition or for the convenience of any party are not medically necessary. The fact that a provider may prescribe, administer, or recommend services or care does not make it medically necessary, even if it is not listed as a membership limitation or an ineligible need in these guidelines. To help determine medical necessity, Unity HealthShare[SM] may request the member's medical records and may require a second opinion from an affiliated provider.

Member(s). A person(s) who qualifies to receive voluntary sharing of contributions for eligible medical needs per the membership clearing house instructions, guidelines, and membership type.

Member Shared Responsibility Amounts (MSRA). The amounts of an eligible need that do not qualify for sharing because the member is responsible for those amounts.

Membership. All members of Unity HealthShare[SM].

Membership Eligibility Manual. The reference materials that contain the criteria used to determine if a potential member is eligible for participation in the membership and if any membership limitations apply.

Membership Type. HCSM sharing options are available with different member shared responsibility amounts (MSRA) and sharing limits as selected in writing on the membership application and approved by Unity HealthShare[SM].

Monthly Contributions. Monetary contributions, excluding the annual membership fee, voluntarily given to Unity HealthShare[SM] to hold as an escrow agent and to disburse according to the membership escrow instructions.

Need(s). Charges or expenses for medical services from a licensed medical practitioner or facility arising from an illness or accident for a single member.

Non-affiliated Practitioner. Medical care professionals or facilities that are not participating within our current network.

Pre-existing Condition. Any illness or accident for which a person has been diagnosed, received medical treatment, been examined, taken medication, or had symptoms within 24 months prior to the application date. Symptoms include but are not limited to the following: abnormal discharge or bleeding; abnormal growth/break; cut or tear; discoloration; deformity; full or partial body function loss; obvious damage, illness, or abnormality; impaired breathing; impaired motion; inflammation or swelling; itching; numbness; pain that interferes with normal use; unexplained or unplanned weight gain or loss exceeding 25% of the total body weight occurring within a six-month period; fainting, loss of consciousness, or seizure; abnormal results from a test administered by a medical practitioner.

Usual, Customary and Reasonable (UCR). The lesser of the actual charge or the charge most other providers would make for those or comparable services or supplies, as determined by Unity HealthShare[SM].

CONTRIBUTORS' INSTRUCTIONS AND CONDITIONS

By submitting monthly contributions, the contributors instruct Unity HealthShare[SM] to share clearing house funds in accordance with the membership instructions. Since Unity HealthShare[SM] has nothing to gain or lose financially by determining if a need is eligible or not, the contributor designates Unity HealthShare[SM] as the final authority for the interpretation of these guidelines. By participation in the membership, the member accepts these conditions as enforceable and binding.

Medical Expenses not generally shared by HCSM

Only needs incurred on or after the membership effective date are eligible for sharing under the membership instructions. The member (or the member's provider) must submit a request for sharing in the manner and format specified by Unity HealthShare[SM]. This includes, but is not limited to, a Need Processing Form, standard industry billing forms (HCFA 1500 and/or most recent UB form), and may include medical records. All participating members have a responsibility to abide by the Members' Rights and Responsibilities published by Unity HealthShare[SM] and included at the end of these guidelines.

Needs arising from any one of the following are not eligible for sharing under the membership clearing house instructions:

1. Any medical care outside of a hospital, except in the case of a needed surgery due to an accident. Members may be able to use out-patient facilities based upon the nature of the medical need and at the sole discretion of Unity HealthShare[SM]. In addition, some plans of Unity HealthShare[SM] include primary, urgent ,and specialty care. See the Appendix for your plan specifics.
2. Treatment or referrals received or obtained from any family member including, but not limited to, father, mother, aunt, uncle, grandparent, sibling, cousin, dependent, or any in-laws.
3. Pre-existing Conditions. Pre-existing conditions may vary based on plan option. Please see Appendix for specific plan details.
4. Illness or injuries caused by member negligence or for which the member has acted negligently in obtaining treatment. This could be documented by, but is not limited to, review of medical records or treatment plans by a licensed medical physician.
5. Procedures or treatments that are not recognized and approved by the American Medical Association (AMA) or that are illegal. Includes procedures not approved by the AMA for a given application, procedures still in clinical trials, procedures that are classified as experimental, or unproven interventions and therapies.
6. Lifestyles or activities engaged in after the application date that conflicts with the Statement of Beliefs (on the membership application).
7. Transportation (e.g., ambulance, etc.) for conditions that are not life-threatening, unless failure to immediately transport the member will seriously jeopardize the member's life; the additional expense for transportation to a facility that is not the nearest facility capable of providing medically necessary care; or charges in excess of $10,000 for transportation by air.

8. Congenital birth defects.
9. Elective cosmetic surgery.
10. Breast implants (placement, replacement, or removal) and complications related to breast implants, including abnormal mammograms, unless related to an otherwise eligible need.
11. Elective abortion of a viable fetus/embryo, unless medically necessary to protect the life of the mother.
12. Infertility testing or treatment, as well as any birth control measures to prevent conception (i.e., the pill, IUDs, shots, etc.)
13. Sterilization or reversals (vasectomy and tubal ligation).
14. Hysterectomy without first obtaining two independent opinions (neither physician may be a partner or other affiliate of the other). Both doctors must examine the patient prior to surgery and both must find that a hysterectomy is medically necessary. The member is responsible to ensure that both physicians submit medical necessity to Unity HealthShare℠ prior to surgery. Failure to follow these procedures will result in a finding of ineligibility for sharing by the membership.
15. Weight control and management including nutritional counseling for weight loss, weight gain, or health maintenance.
16. Hospital stays exceeding 60 days per medical need or additional charges for a private hospital room if a semi-private hospital room is available.
17. Any exams, physicals, or tests for which there are no specific medical symptoms, diagnosis in advance, or risk assessment testing.
18. Adult immunizations, HPV immunizations, and flu shots unless covered under an Aliera Healthcare part of the plan.
19. Chelation.
20. Physical therapy or occupational therapy that is not pre-authorized. Pre-authorized treatments are limited to a combined 6 visits in any calendar year.
21. Charges for emergency room visits and/or surgical removal for foreign objects placed in nose or ears by a child over five (5) years of age. Removal of foreign objects that can be done in an office setting will be reviewed under regular MSRAs or the Office Visit consult fee options.
22. Medication or procedures not requiring a prescription.
23. Purchase or rental of durable or reusable equipment or devices (e.g. oxygen, orthotics, hearing aids, prosthetics, and external braces), including associated supplies, diagnostic testing, or office visits.
24. Needs for active members submitted 9 months after the date of treatment. Needs for inactive members submitted 6 months after the date of treatment.
25. Dental services and procedures, including periodontics, orthodontics, temporomandibular joint disorder (TMJ), or orthognathic surgery. Includes hospital charges for dental work done under general anesthesiology. Dental work required during surgery from an accident shall be eligible for cost sharing when the dental work is required after an accident and while the member is still admitted to a hospital.
26. Optometry, vision services, glasses, contacts, supplies, vision therapy, refraction services, or office visits.
27. Psychiatric or psychological counseling, testing, treatment, medication, and hospitalization.
28. Mental or psychiatric health, learning disability, developmental delay, autism, behavior disorders, eating disorders, neuropsychological testing, alcohol/substance abuse counseling, attention deficit disorder, or hyperactivity.
29. Speech therapy (except for a deficit arising from stroke/trauma).
30. Circumcisions.
31. Self/inflicted or intentional injuries.
32. Acts of war.
33. Exposure to nuclear fuel, explosives, or waste.
34. Occupational injury resulting from an injury incurred while performing any activity for profit.
35. Consumption of a prescription drug not prescribed for the member or prescription drug prescribed for the member and taken in excess that causes an adverse reaction; illicit drug use by a member.
36. Illness or injury caused by the illegal activities of the member or the member's family, including misdemeanors and felonies, regardless of whether or not charges are filed.
37. Treatment, care, or services that is not medically necessary.
38. Emergency room services, unless treatment at an emergency room is the only legitimate option because of the severity of the condition and lack of availability of treatment at an alternative facility.
39. Sexually transmitted diseases.
40. Diseases, including HIV/AIDS, due to tattoos, body piercing, or life-style choices.
41. Allergy testing or immunotherapy treatment.
42. Second surgeries are eligible for sharing based on member's treatment plan and are subject to third party case management approval. Second surgeries on a previously eligible surgical need are not eligible unless the

member has followed through with the treatment plan laid out for him or her by their physician or complications occur within 15 days of eligible surgery.
43. Genetic testing and counseling.
44. Handling charges, conveyance fees, stat fees, shipping/handling fees, administration fees, missed appointment fees, telephone/email consultations, or additional charges for services supplied in an after-hours setting.
45. Drug testing unless required by membership.
46. Sexual dysfunction services.
47. Cancer sharing eligibility is different based on plan option chosen. AlieraCare plans have a 12 month wait period for cancer. Sharing is available the 1st day of the 13 month of continuous membership. Any pre-existing or recurring cancer condition is not eligible for sharing. Cancer sharing will not be available for individuals who have cancer at the time of or five (5) years prior to application. If cancer existed outside of the 5-year time frame of a pre-exisitng look-back, the following must be met in the five (5) years prior to application, to be eligible for future, non-recurring cancer incidents. 1. The condition had not been treated nor was future treatment prescribed/planned; 2. The condition had not produced harmful sypmtoms (only benign symptoms); 3. The condition had not deteriorated.
48. Adenoid removal surgery eligible for sharing only at 50% if member has had a prior surgery to remove tonsils and the adenoids were not removed at the same time.
49. Personal aircraft includes hang gliders, parasails, ultra-lights, hot air balloons, sky/diving, and any other aircraft not operated by a commercially licensed public carrier.
50. Extreme sports: Sports that voluntarily put an individual in a life-threatening situation. Sports such as but not limited to “free climb” rock climbing, parachuting, fighting, matrial arts, racing, cliff diving, powerboat racing, air racing, motorcycle racing, extreme skiing, wingsuit, etc…

First 60 Days of Participation. *For sixty (60) days after Enrollment Date as a Sharing Member, medical expenses for any reason, other than accidents, illness or injury, are not eligible for sharing among members.*

PRE-AUTHORIZATION REQUIRED

Non-Emergency Surgery, Procedure, or Test. The member must have the following procedures or services pre-authorized as medically necessary prior to receiving the service. Failure to comply with this requirement will render the service not eligible for sharing.

Hospitalizations. Non-emergency prior to admission; emergency visits notification to Unity HealthShare℠ within 48 hours.

- MRI studies/CT scans/Ultrasounds
- Sleep studies must be completed in one session
- Physical or occupational therapy
- Speech therapy under limited circumstances only
- Cardiac testing, procedures, and treatments
- In-patient cancer testing, procedures, and treatments
- Infusion therapy within facility
- Nuclide studies
- EMG/EEG
- Ophthalmic procedures
- ER visits, emergency surgery, procedure, or test: Non-emergency use of the emergency room is not eligible for sharing. Unity HealthShare℠ must be notified of all ER visits within 48 hours. Medical records will be reviewed for all ER visits to determine eligibility. An emergency is defined as treatment that must be rendered to the patient immediately for the alleviation of the sudden onset of an unforeseen illness or injury that, if not treated, would lead to further disability or death. Examples of an emergency include, but are not limited to, severe pain, choking, major bleeding, heart attack, or a sudden, unexplained loss of consciousness.

Eligibility for Cancer Needs. In order for needs related to cancer hospitalization of any type to be eligible (e.g. breast, colorectal, leukemia, lymphoma, prostate, skin, etc.), the member must meet the following requirements:

The member is required to contact Unity HealthShare℠ within 30 days of diagnosis. If the member fails to notify Unity HealthShare℠ within the 30-day time frame, the member will be responsible for 50% of the total allowed charges after the MRSA(s) has been assessed to the member for in-patient cancer hospitalization.

Early detection provides the best chance for successful treatment and in the most cost effective manner. Effective January 1, 2017, the membership will require that all members aged 40 and older receive appropriate screening tests every other year – mammogram or thermography and pap smear with pelvic exams for women and PSA testing for men.

Failure to obtain biannual mammograms and gynecological tests listed above for women or PSA tests for men will render future needs for breast, cervical, endometrial, ovarian, or prostate cancer ineligible for sharing.

DISPUTE RESOLUTION AND APPEAL

Unity HealthShare[SM] is a voluntary association of like-minded people who come together to assist each other by sharing medical expenses. Such a sharing and caring association does not lend itself well to the mentality of legally enforceable rights. However, it is recognized that differences of opinion will occur, and that a methodology for resolving disputes must be available. Therefore, by becoming a Sharing Member of Unity HealthShare[SM], you agree that any dispute you have with or against Unity HealthShare[SM], its associates, or employees will be settled using the following steps of action, and only as a course of last resort.

If a determination is made with which the sharing member disagrees and believes there is a logically defensible reason why the initial determination is wrong, then the sharing member may file an appeal.

A. **1st Level Appeal**. Most differences of opinion can be resolved simply by calling Unity HealthShare[SM] who will try to resolve the matter within ten (10) working days in writing.

B. **2nd Level Appeal.** If the sharing member is unsatisfied with the determination of the member services representative, then the sharing member may request a review by the Internal Resolution Committee, made up of three Unity HealthShare[SM] officials: the needs processing manager, the assistant director, and the executive director. The appeal must be in writing, stating the elements of the dispute and the relevant facts. Importantly, the appeal should address all of the following:

1. What information does Unity HealthShare[SM] have that is either incomplete or incorrect?
2. How do you believe Unity HealthShare[SM] has misinterpreted the information already on hand?
3. Which provision in the Unity HealthShare[SM] Guidelines do you believe Unity HealthShare[SM] applied incorrectly?

Within thirty (30) days, the Internal Resolution Committee will render a written decision.

C. **3rd Level Appeal.** Should the matter remain unresolved, then the aggrieved party may ask that the dispute be submitted to three sharing members in good standing and randomly chosen by Unity HealthShare[SM], who shall agree to review the matter and shall constitute an External Resolution Committee. Within thirty (30) days the External Resolution Committee shall render their opinion in writing.

D. **Final Appeal.** If the aggrieved sharing member disagrees with the conclusion of his/her fellow sharing members, then the aggrieved party may ask that the dispute be submitted to a medical expense auditor, who shall have the matter reviewed by a panel consisting of personnel who were not involved in the original determination and who shall render their opinion in writing within thirty (30) days.

E. **Mediation and Arbitration.** If the aggrieved sharing member disagrees with the conclusion of the Final Appeal Panel, then the matter shall be settled by mediation and, if necessary, legally binding arbitration in accordance with the Rules of Procedure for Christian Conciliation of the Institute for Christian Conciliation, a division of Peacemaker Ministries. Judgment upon an arbitration decision may be entered in any court otherwise having jurisdiction. Sharing members agree and understand that these methods shall be the sole remedy for any controversy or claim arising out of the Sharing Guidelines and expressly waive their right to file a lawsuit in any civil court against one another for such disputes, except to enforce an arbitration decision. Any such arbitration shall be held in Fredericksburg, Virginia, subject to the laws of the Commonwealth of Virginia. Unity HealthShare[SM] shall pay the fees of the arbitrator in full and all other expenses of the arbitration; provided, however, that each party shall pay for and bear the cost of its own transportation, accommodations, experts, evidence, and legal counsel, and provided further that the aggrieved sharing member shall reimburse the full cost of arbitration should the arbitrator determine in favor of Unity HealthShare[SM] and not the aggrieved sharing member. The aggrieved sharing member agrees to be legally bound by the arbitrator's decision. The Rules of Procedure for Christian Conciliation of the Institute for Christian Conciliation, a division of Peacemaker Ministries, will be the sole and exclusive procedure for resolving any dispute between individual members and Unity HealthShare[SM] when disputes cannot be otherwise settled.

PART III

Your Summary of Cost Sharing, Eligible Needs, & Limits

See the Appendix for other limits and conditions of sharing by plan

MEDICAL EXPENSES COVERED*

Medical Expenses Eligible for Sharing. Medical costs are shared on a per person per incident basis for illnesses or injuries incurring medical expenses after the membership effective date when medically necessary and provided by or under the direction of licensed physicians, osteopaths, urgent care facilities, clinics, emergency rooms, or hospitals (inpatient and outpatient), or other approved providers of conventional or naturopathic care. Unless otherwise limited or excluded by these Guidelines, medical expenses eligible for sharing include, but are not limited to, physician and hospital services, emergency medical care, surgical procedures, medical testing, X-rays, ambulance transportation, and prescriptions. Co-expenses do not apply towards a members MSRA.

1. **Telemedicine.** Telemedicine is included in most programs offered by Unity HealthShare[SM] and Aliera Healthcare as your first line of defense. Your membership provides you and your family 24/7/365 access to a U.S. Board certified medical doctor.
2. **Preventive.** Most programs from either Unity Healthshare[SM] or Aliera provide everyone with the necessities of the 63 preventive care services as outlined by the United States Preventive Task force. (Excludes CarePlus Advantage.) Preventive care includes the PCP office visit and does not require a co-expense or consult fee.
3. **Labs & Diagnostics.** Your labs and diagnostics are covered when visiting a PCP or urgent care facility in network when your plan includes primary and urgent care. For labs at hospitals or other facilities, your MSRA will apply and you will be required to pay a co-expense of $25.
4. **Urgent Care.** If your plan provides cost sharing for urgent care, you will have the added benefit of enjoying the ability to choose an urgent care facility in lieu of an emergency room. See the Appendix for any urgent care options and any limitations to plan.
5. **Primary Care.** Depending on your plan choice, primary care is at the core of preventing medical issues from escalating into a more catastrophic need. See Appendix for the specific plan details.
6. **Specialty Care.** Specialty care is included in most plans, but has limits defined by your specific plan design. Refer to the Appendix for specific details of MSRA and co-expense requirements.
7. **X-rays.** X-rays listed on your plan details in the Appendix are for imaging services at PCP or urgent care facilities only and requires a $25 read fee per view at time of service. Your MSRA will apply to all other X-rays. MRI, CT Scans and other diagnostics must be paid with your MSRA before cost sharing is provided.
8. **Chronic Maintenance**. Chronic maintenance is eligible when a member has chosen a plan with chronic maintenance specifically included and a listing of the maximum number of allowable visits. See ‘Appendix A’ attached hereto.
9. **Emergency Room.** Emergency room services for stabilization or initiation of treatment of a medical emergency condition provided on an outpatient basis at a hospital, clinic, or urgent care facility, including when hospital admission occurs within twenty-three (23) hours of emergency room treatment.
10. **Hospitalization.** Hospital charges for inpatient or outpatient hospital treatment or surgery for a medically diagnosed condition.
11. **Surgical Benefits.** Non life threatening surgical benefits are not available for the first 60 days of membership for Premium plans and all other plans require 6 month wait period. **Please verify eligibility by calling Members Services before receiving any surgical services.**
12. **Prescription Drugs.** The AlieraCare plan includes a service by RX Valet, which includes cost sharing for prescription drugs. See Appendix for details.
13. **Physical Therapy.** Up to six (6) visits per membership year for physical therapy by a licensed physical therapist.
14. **Ambulance.** Emergency land or air ambulance transportation to the nearest medical facility capable of providing the medically necessary care to avoid seriously jeopardizing the sharing member’s life or health.
15. **Naturopathic and/or Alternative Treatments.** Does not included chiropractic services
16. **Prosthetics and their replacement, if medically necessary.** This is not an eligible sharing expense
17. **Medical Costs incurred outside the United States.** Charges for the care and treatment of a medically diagnosed condition when treatment outside the United States is financially beneficial or when traveling or residing outside the United States. Eligibility of such charges are subject to all other provisions of the Guidelines. Medical billing is requested to be submitted in English and converted to U.S. currency.
18. **Smoking Cessation.** Members with preventive coverage who have acknowledged they smoke and made an additional contribution are provided the opportunity to obtain free smoking cessation medication and counseling.

19. **Competitive Sports.** Plan holders who participate in organized and/or sanctioned competitive sports are eligible for $5,000 (max) of sharing per incident at an emergency room, subject to the member-shared responsibility amount.
20. **Maternity.** Maternity medical expenses are only eligible for sharing in certain Plans. Please see the Appendix for your specific plan design. Medical expenses for maternity ending in a delivery by emergency cesarean section that is medically necessary are eligible for sharing up to $8,000 subject to the applicable Member Shared Responsibility Amount. Medical expenses for a newborn arising from complications at the time of delivery, including, but not limited to, premature birth, are treated as a separate incident and limited to $50,000 of eligible sharing, subject to the Member Shared Responsibility Amount. See the Appendix for specific sharing inclusions and limits for your plan choice.

**Medical Expense Incident* is any medically diagnosed condition receiving medical treatment and incurring medical expenses of the same diagnosis. All related medical bills of the same diagnosis comprise the same incident. Such expenses must be submitted for sharing in the manner and form specified by Unity HealthShare[SM]. This may include, but not be limited to, standard industry billing forms (HCFA1500 and/or UB 92) and medical records. Members share these kinds of costs.

LIMITS OF SHARING (MAXIMUM PAYABLE)

Total eligible needs shared from member contributions are limited as defined in this section and as further limited in writing to the individual member.

1. **Lifetime Limits.** $1,000,000: the maximum amount shared for eligible needs over the course of an individual member's lifetime.
2. **Annual Limits.** The maximum amount shared for eligible needs per member per 12 month plan term.
3. **Per Term.** The limit for each term of a sharing plan. Generally, means annually except in the case of short-term cost sharing.
4. **Per Incident.** The occurrence of one particular sickness, illness, or accident.
5. **Cancer Limits when applicable.** Cancer is limited to a maximum per term of $500,000 when applicable
6. **Member Shared Responsibility Amounts (MSRA).** Eligible needs are limited to the amounts in excess of the MSRA, which are applied per individual member per the plan year.
7. **MSRA(s).** The eligible amount that does not qualify for sharing based on the membership type chosen by the member.
8. **Office Visit/Urgent Care.** Office visits, in particular, primary and urgent, have certain limits and inclusions. Please refer to the Appendix for your specific plan.
9. **Non-Affiliated Practitioner.** Services rendered by a non-affiliated practitioner will not be eligible for sharing nor will any amount be applied to your MRSA unless specified differently in the plan details contained herein..
10. **Organ Transplant Limit.** Eligible needs requiring organ transplant may be shared up to a maximum of $150,000 per member. This includes all costs in conjunction with the actual transplant procedure. Needs requiring multiple organ transplants will be considered on a case-by-case basis.
11. **Cost Sharing for Pre-Existing Conditions.** Cost sharing is not available for pre-exising conditions for the first two years of membership.
12. **Overnight Sleep Testing Limit.** All components of a polysomnogram must be completed in one session. A second overnight test will not be eligible for sharing under any circumstance. Overnight sleep testing must be medically necessary and will require pre-authorization (see item 8). Allowed charges will not exceed the Usual, Customary, and Reasonable charges for the area.

Other Resources. Needs do not qualify for sharing to the extent that they are payable by an institutional source such as insurance, VA, Tricare, private grants, or by a liable third party (primary, auto, home insurance, educational, etc.). If the member does not cooperate fully, the need will not be eligible for sharing. The MRSA's are waived up to the maximum MRSA's per membership type only if a liable third party or institutional source pays on the member's behalf. Sharing of monthly contributions for a need that is later paid or found to be payable by an institutional source or a liable third party will automatically allow Unity HealthShare[SM] full rights to recover from the member the amounts shared on their behalf.

See Appendix A below for Additional Sharing Limits by Plan Level

APPENDIX A: PLAN DETAILS

PPO Network	Multiplan | PHCS Specific Services		
PLAN Level	**VALUE[2]**	**PLUS[2]**	**PREMIUM[3]**
Preventative Care	100%	100%	100%
Telemedicine***	100%	100%	100%
Primary Care (PCP)	1 per Year* $20 Consult Fee	3 per Year* $20 Consult Fee	5 per Year* $20 Consult Fee
PCP Chronic Visits	n/a	n/a	Included @ PCP
Urgent Care	n/a	1 per Year* $20 Consult Fee	2 per Year* $20 Consult Fee
Labs & Diagnostics*	Preventive Only	PCP & Urgent Care**	PCP & Urgent Care**
X-rays**	Preventive Only	100%**	100%**
Rx Discount	Included	Included	Included
Pediatrics	Preventive Only	Preventive Only	As Primary Care
OB/GYN	Preventive Only	Preventive Only	As Primary Care
UNITY HealthShare [1,4,5]			
Hospitalization	Included	Included	Included
In-Patient Surgery	Included	Included	Included
Out-Patient Surgery	Included	Included	Included
Specialty Care [8]	n/a	n/a	$75 Consult Fee (100% after MSRA)
Emergency Room [6]	Full MSRA	$500 MSRA	$300 MSRA
Maternity [7]	n/a	n/a	$5,000 Max
Per Incident Maximum Limit	$150,000	$250,000	$500,000
Lifetime Maximum Limit	$1,000,000	$1,000,000	$1,000,000

*Annual Physical unavailable until 9 months after effective date; Lifestyle lab testing not included.

**$25 Read-fee applies for X-rays at urgent care, per X-ray read (rate may vary by city).

***Telemedicine services not available in some states.

1. Pre-existing conditions have a 24-month waiting period
2. Surgical benefits are not available for the first 6 months
3. Surgical benefits are not available for the first 2 months
4. Cancer coverage is provided after 12 months of continuous coverage, if a pre-existing cancer condition did not exist prior to or at the time of application
5. Qualified dependents are under the age of 20. Ages 20-26 can qualify as a dependent, if proven to be a full-time student
6. ER visits are subject to review, and are meant only for life threatening situations. Maximum out-of-pocket is $300 or $500 depending on plan chosen
7. Maternity benefits are not available for the first 10 months
8. The Consult Fee is in addition to the cost of your specialty visit and does not apply toward your annual MSRA

Administrative and Conditional Fees:

- $125 one-time application fee per enrollment
- Add $60 for persons who smoke
- Add Additional $130 per member for additional $500,000 per incident rider

Unity HealthShare plans do not promise to pay medical claims, but follow standard claim eligibility review protocols described in plan.

Products NOT available in: AK, HI, MD, ME, PR, WA, WY; subject to change w/o prior notice.

APPENDIX B: TERMS, CONDITIONS, & SPECIAL CONSIDERATIONS

1. The Welcome Kit you received electronically includes this Member Guide, your Membership Card(s), a Welcome Letter, and important information to activate your membership and any applicable accessory services.
2. Keep your Membership Card with you at all times to present to a provider to confirm eligibility.
3. The ACA is subject to change at any time; Aliera reserves the right to adhere to those changes without notice to the Member.
4. Activate your Plan Membership by following the instructions in this Member Guide.
5. Set up your telemedicine account by following the instructions on the Welcome Letter. Within three weeks of enrollment in Aliera's telemedicine partnering company, Members receive ID Card(s) for the telemedicine service along with instructions on how to utilize the service.
6. Telemedicine operates subject to state regulations and may not be available in certain states.
7. Because more than 80% of primary medical conditions can be resolved by your telemedicine provider, Members must always call the telemedicine provider first to receive medical attention.
8. Telemedicine phone consultations are available 24/7/365, with face-to-face internet consultations available between the hours of 7 a.m. and 9 p.m., Monday – Friday.
9. Telemedicine does not guarantee that a prescription will be written.
10. Telemedicine does not prescribe DEA-controlled substances, non-therapeutic drugs, and certain other drugs which may be harmful because of their potential for abuse. Telemedicine doctors reserve the right to deny care for potential misuse of services.
11. Durable Medical Equipment (DME) – crutches, etc. – is not included in your Plan. Members will be charged for DME at time of service.
12. Aliera cannot guarantee that a provider will accept an Aliera Plan if the Member fails to contact the Aliera Concierge Service first.
13. Member Care Specialists are available to assist you, Monday through Friday, 8 a.m. to 8 p.m. ET at (844) 834-3456. If you call after hours, follow the prompts.
14. At the time of service, payment of $20 (on average) is due for the consultation, and a $25 read fee for X-rays, per X-ray read, if needed. Consult fees vary in different states and may be higher in some cities, including but not limited to, New York City, Chicago, Detroit, Miami, Sacramento, Los Angeles, and San Francisco.
15. Plans may vary from state to state. Providers may be added or removed from Aliera's network at any time without notice.
16. If you become sick while traveling within the U.S., contact your telemedicine provider first. If directed by the telemedicine doctor to seek further treatment, visit www.UnityHealthshare.com and click on "Network" to search by city, state, or zip code for a list of the nearest in-network providers.
17. Not all geographical areas are serviced by Aliera Healthcare. Should a Member visit an emergency room because urgent care facilities are unavailable in the Member's area, Aliera offers a one-time, once-a-year, $105 credit (ex gratia) to the Member to help offset the costs incurred.
18. If an urgent care facility is used for a primary care visit for sick care, an additional fee of $40 will be payable at time of service.
19. Aliera Healthcare telemedicine partners do not replace the Primary Care Provider.
20. Primary Care is defined as "episodic primary care" or "sick care." Members are responsible for paying a consult fee at the time of service; no consult fee is due for preventive service.
21. Most network facilities are able to accommodate both urgent care and primary care needs.
22. Not all PPO providers accept a AlieraCare Plan. While Aliera offers one of the largest PPO networks in the country, some providers may not participate. Provider network online search databases are updated per their own schedule and may be out of synch with your healthcare, specialty care, or hospital provider.

DISCLOSURES

1. Aliera Healthcare, the Aliera Healthcare logo, and other plan or service logos are trademarks of Aliera Healthcare, Inc. and may not be used without written permission.
2. Aliera and Unity programs are NOT insurance. Aliera Healthcare/Unity HealthShare℠ does not guarantee the quality of services or products offered by individual providers. Members may change providers upon 30 days' notice if not satisfied with the medical services provided.
3. Aliera's Healthcare Plans cover services only to Members and dependents on your Plan.
4. Aliera reserves the right to interpret the terms of this membership to determine the level of medical services received hereunder.
5. This membership is issued in consideration of the Member's application and the Member's payment of a monthly fee as provided under these Plans. Omissions and misstatements, or incorrect, incomplete, fraudulent, or

intentional misrepresentation to the assumed risk in your application may void your membership, and services may be denied.

Abbreviations

ACA	Affordable Care Act (Obamacare)	HCSM	Health Care Sharing Ministry
CMS	Center for Medicare and Medicaid Services	MEC	Minimum Essential Coverage
DEA	Drug Enforcement Administration	PCP	Primary Care Provider
DME	Durable Medical Equipment	PPO	Participating Provider Organization
DPCMH	Direct Primary Care Medical Home Plans	UC	Urgent Care

APPENDIX C: LEGAL NOTICES

The following legal notices are the result of discussions by Unity HealthShare(SM) or other healthcare sharing ministries with several state regulators and are part of an effort to ensure that Sharing Members understand that Unity HealthShare[SM] is not an insurance company and that it does not guarantee payment of medical costs. Our role is to enable self-pay patients to help fellow Americans through voluntary financial gifts.

GENERAL LEGAL NOTICE

This program is not an insurance company nor is it offered through an insurance company. This program does not guarantee or promise that your medical bills will be paid or assigned to others for payment. Whether anyone chooses to pay your medical bills will be totally voluntary. As such, this program should never be considered as a substitute for an insurance policy. Whether you receive any payments for medical expenses and whether or not this program continues to operate, you are always liable for any unpaid bills.

STATE SPECIFIC NOTICES

Alabama Code Title 22-6A-2
Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Arizona Statute 20-122
Notice: the organization facilitating the sharing of medical expenses is not an insurance company and the ministry's guidelines and plan of operation are not an insurance policy. Whether anyone chooses to assist you with your medical bills will be completely voluntary because participants are not compelled by law to contribute toward your medical bills. Therefore, participation in the ministry or a subscription to any of its documents should not be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this ministry continues to operate, you are always personally responsible for the payment of your own medical bills.

Arkansas Code 23-60-104.2
Notice: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor plan of operation is an insurance policy. If anyone chooses to assist you with your medical bills, it will be totally voluntary because participants are not compelled by law to contribute toward your medical bills. Participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive a payment for medical expenses or if this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Florida Statute 624.1265
Unity HealthShare[SM] is not an insurance company, and membership is not offered through an insurance company. Unity HealthShare[SM] is not subject to the regulatory requirements or consumer protections of the Florida Insurance Code.

Georgia Statute 33-1-20
Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Idaho Statute 41-121
Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Illinois Statute 215-5/4-Class 1-b
Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation constitute or create an insurance policy. Any assistance you receive with your medical bills will be totally voluntary. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Whether or not you receive any payments for medical expenses and whether or not this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Indiana Code 27-1-2.1
Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor its plan of operation is an insurance policy. Any assistance you receive with your medical bills will be totally voluntary. Neither the organization nor any other participant can be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Whether or not you receive any payments for medical expenses and whether or not this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Kentucky Revised Statute 304.1-120 (7)
Notice: Under Kentucky law, the religious organization facilitating the sharing of medical expenses is not an insurance company, and its guidelines, plan of operation, or any other document of the religious organization do not constitute or create an insurance policy. Participation in the religious

organization or a subscription to any of its documents shall not be considered insurance. Any assistance you receive with your medical bills will be totally voluntary. Neither the organization nor any participant shall be compelled by law to contribute toward your medical bills. Whether or not you receive any payments for medical expenses, and whether or not this organization continues to operate, you shall be personally responsible for the payment of your medical bills.

Louisiana Revised Statute Title 22-318,319
Notice: The ministry facilitating the sharing of medical expenses is not an insurance company. Neither the guidelines nor the plan of operation of the ministry constitutes an insurance policy. Financial assistance for the payment of medical expenses is strictly voluntary. Participation in the ministry or a subscription to any publication issued by the ministry shall not be considered as enrollment in any health insurance plan or as a waiver of your responsibility to pay your medical expenses.

Maine Revised Statute Title 24-A, §704, sub-§3
Notice: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. Participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Maryland Article 48, Section 1-202(4)
Notice: This publication is not issued by an insurance company nor is it offered through an insurance company. It does not guarantee or promise that your medical bills will be published or assigned to others for payment. No other subscriber will be compelled to contribute toward the cost of your medical bills. Therefore, this publication should never be considered a substitute for an insurance policy. This activity is not regulated by the State Insurance Administration, and your liabilities are not covered by the Life and Health Guaranty Fund. Whether or not you receive any payments for medical expenses and whether or not this entity continues to operate, you are always liable for any unpaid bills.

Mississippi Title 83-77-1
Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment of medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Missouri Section 376.1750
Notice: This publication is not an insurance company nor is it offered through an insurance company. Whether anyone chooses to assist you with your medical bills will be totally voluntary, as no other subscriber or member will be compelled to contribute toward your medical bills. As such, this publication should never be considered to be insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always personally responsible for the payment of your own medical bills.

Nebraska Revised Statute Chapter 44-311
IMPORTANT NOTICE. This organization is not an insurance company, and its product should never be considered insurance. If you join this organization instead of purchasing health insurance, you will be considered uninsured. By the terms of this agreement, whether anyone chooses to assist you with your medical bills as a participant of this organization will be totally voluntary, and neither the organization nor any participant can be compelled by law to contribute toward your medical bills. Regardless of whether you receive payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills. This organization is not regulated by the Nebraska Department of Insurance. You should review this organization's guidelines carefully to be sure you understand any limitations that may affect your personal medical and financial needs.

New Hampshire Section 126-V:1
IMPORTANT NOTICE This organization is not an insurance company, and its product should never be considered insurance. If you join this organization instead of purchasing health insurance, you will be considered uninsured. By the terms of this agreement, whether anyone chooses to assist you with your medical bills as a participant of this organization will be totally voluntary, and neither the organization nor any participant can be compelled by law to contribute toward your medical bills. Regardless of whether you receive payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills. This organization is not regulated by the New Hampshire Insurance Department. You should review this organization's guidelines carefully to be sure you understand any limitations that may affect your personal medical and financial needs.

North Carolina Statute 58-49-12
Notice: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor its plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be voluntary. No other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally liable for the payment of your own medical bills.

Pennsylvania 40 Penn. Statute Section 23(b)
Notice: This publication is not an insurance company nor is it offered through an insurance company. This publication does not guarantee or promise that your medical bills will be published or assigned to others for payment. Whether anyone chooses to pay your medical bills will be totally voluntary. As such, this publication should never be considered a substitute for insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always liable for any unpaid bills.

South Dakota Statute Title 58-1-3.3
Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an

insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payments for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Texas Code Title 8, K, 1681.001
Notice: This health care sharing ministry facilitates the sharing of medical expenses and is not an insurance company, and neither its guidelines nor its plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the ministry or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this ministry continues to operate, you are always personally responsible for the payment of your own medical bills. Complaints concerning this health care sharing ministry may be reported to the office of the Texas attorney general.

Virginia Code 38.2-6300-6301
Notice: This publication is not insurance, and is not offered through an insurance company. Whether anyone chooses to assist you with your medical bills will be totally voluntary, as no other member will be compelled by law to contribute toward your medical bills. As such, this publication should never be considered to be insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always personally responsible for the payment of your own medical bills.

Wisconsin Statute 600.01 (1) (b) (9)
ATTENTION: This publication is not issued by an insurance company, nor is it offered through an insurance company. This publication does not guarantee or promise that your medical bills will be published or assigned to others for payment. Whether anyone chooses to pay your medical bills is entirely voluntary. This publication should never be considered a substitute for an insurance policy. Whether or not you receive any payments for medical expenses, and whether or not this publication continues to operate, you are responsible for the payment of your own medical bills.

This is NOT Insurance. This is Healthcare Cost Sharing.

www.unityhealthshare.org

www.alieraheathcare.com

Aliera Healthcare
5901 Peachtree Dunwoody Road, Suite B-200
Atlanta Georgia 30328

T**:** 844-834-3456 | e**Fax:** 1-404-937-6557

KROMODIMEDJO DECLARATION

EXHIBIT 12

2019 MEMBER GUIDE

AlieraCare™

VALUE | PLUS | PREMIUM

INDIVIDUAL & FAMILY

Aliera™ HEALTHCARE

AlieraCare Plans are NOT Insurance.

TABLE OF CONTENTS

WELCOME

Welcome to Aliera Healthcare, Inc. | Trinity HealthShare. Thank you for becoming a member. We are committed to providing you and your family with unparalleled service and care at an affordable cost, and we pledge to keep our focus on what's most important – your overall health and wellness.

Please take a few minutes to review the information in this guide. The more informed you are, the easier it will be to get the care you need when you need it the most. Your membership card(s) and this booklet provide important information about your Plan, as well as the steps you need to take to access healthcare at one of the thousands of participating network provider locations. Your welcome information, Member Portal access and temporary member cards are contained in your Welcome Email: please print it and save a copy for reference.

If you have any questions about your Plan, activating your Membership Card, setting up your telemedicine account, Rx discount program, or accessing a healthcare provider, please contact a Member Care Specialist for assistance, **Monday through Friday, 8 a.m. to 8 p.m. ET at (844) 834-3456.**

MEMBER PORTAL

Username and password credentials are needed to enter the Member's portal to update payment or personal information. Visit www.alierahealthcare.com and click the Member Login tab. Your user name and password are on the Welcome Email sent at the time of initial enrollment. Member Services can send you a copy of this email following confirmation of identity.

CONTACT INFORMATION

For general information, account management, monthly contribution, or medical needs, please contact us:

Phone: 844-834-3456

Fax: 404-937-6557

Email: **memberservices@alierahealthcare.com** or **memberservices@trinityhealthshare.org**

Online: **www.alierahealthcare.com** or **www.trinityhealthshare.org**

Mail: PO Box 28220 Atlanta, GA 30358

DISCLAIMER

AlieraCare offering by Trinity HealthShare, through Aliera Healthcare, Inc., is a faith-based medical needs sharing membership. Medical needs are only shared by the members according to the membership guidelines. Our members agree to the Statement of Beliefs and voluntarily submit monthly contributions into a cost-sharing account with Trinity HealthShare, acting as a neutral clearing house between members. Organizations like ours have been operating successfully for years. We are including the following caveat for all to consider:

> This publication or membership is not issued by an insurance company, nor is it offered through an insurance company. This publication or the membership does not guarantee or promise that your eligible medical needs will be shared by the membership. This publication or the membership should never be considered as a substitute for an insurance policy. If the publication or the membership is unable to share in all or part of your eligible medical needs, or whether or not this membership continues to operate, you will remain financially liable for any and all unpaid medical needs.
>
> This is not a legally binding agreement to reimburse any member for medical needs a member may incur, but is instead, an opportunity for members to care for one another in a time of need, to present their medical needs to other members as outlined in the membership guidelines. The financial assistance members receive will come from other members' monthly contributions that are placed in a sharing account, not from Trinity HealthShare.

PLAN SERVICES & MEMBERSHIP AT A GLANCE

Aliera Healthcare services in conjunction with Trinity HealthShare cost-sharing creates a full range of services and offerings, each part summarized below:

PREVENTIVE CARE

As part of our solution, the Plans cover medical services recommended by the USPSTF and outlined in the ACA for preventive care. There is zero out of pocket expense and zero obligation to reach the Member Shared Responsibility Amount (MSRA) for any scheduled preventive care service or routine in-network check-up, pap smear, flu shot and more. It's easier to stay healthy with regular preventive care.

PRIMARY CARE

Primary care is at the core of an Aliera plan, and we consider it a key step in living a healthier lifestyle. Our model is based on an innovative approach to care that is truly patient-centered, combining excellent service with a modern approach. This includes medical care needs such as primary care, office visits, sick care, and the general care of a member's day to day medical needs.

CHRONIC MAINTENANCE

With AlieraCare Premium, members are eligible to receive chronic care management from their primary care physician for conditions such as diabetes, asthma, blood pressure, cardiac conditions, etc.

LABS & DIAGNOSTICS

Labs at in-network facilities are included.

TELEMEDICINE

With full 24/7 365-day access to a board-certified physician, it has never been simpler to stay healthy. You can contact them easily by phone or via video chat. If it's something minor such as a sinus infection, poison ivy or pink eye they can even send a prescription right over to your pharmacist.

URGENT CARE

For those medical situations that can't wait or are more complex than primary care services, AlieraCare plans offer access to Urgent Care facilities at hundreds of medical centers throughout the United States.

MEMBERSHIP

Trinity HealthShare is a health care sharing ministry (HCSM) which acts as an organizational clearing house to administer sharing contributions across qualifying members healthcare needs. The AlieraCare membership is NOT health insurance. The membership is based on a religious tradition of mutual aid, neighborly assistance, and burden sharing. The membership does not subsidize self-destructive behaviors and lifestyles, but is specifically tailored for individuals who maintain a healthy lifestyle, make responsible choices in regards to health and care, and believe in helping others. Because Trinity HealthShare is a religious organization, members are required to agree with the organizations Statement of Beliefs; see Part II of this guide for the full description and membership details.

SPECIALTY CARE

For most everyday medical conditions, your PCP is your one-stop medical shop. However, there are cases when it's time to see a specialist who's had additional education and been board certified for that specialty. For situations like these, the AlieraCare Premium plans provides specialty care offerings after the members shared responsibility has been met (MSRA). A member will need to receive a PCP referral to see a specialist for treatment or consultation outside of their scope of knowledge.

HOSPITALIZATION

Hospitalization is eligible, once the Member Shared Responsibility Amount has been met, under all the individual plans.

SURGERY

Both in-patient and out-patient procedures are eligible, once the Member Shared Responsibility Amount has been met, under all individual plans.

EMERGENCY ROOM

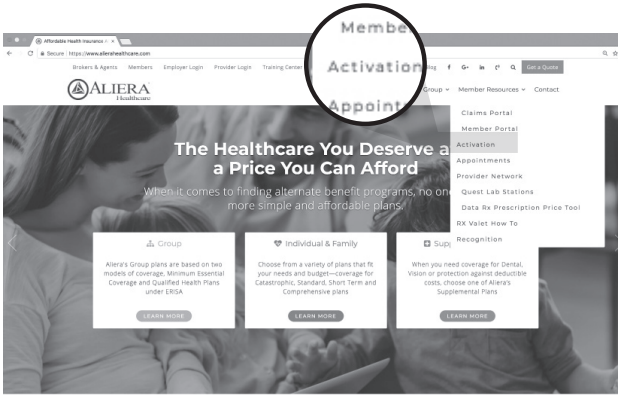
An emergency is defined as treatment that must be rendered to the patient immediately for the alleviation of the sudden onset of an unforeseen illness or injury that, if not treated, would lead to further disability or death. Examples of an emergency include, but are not limited to, severe pain, choking, major bleeding, heart attack, or a sudden, unexplained loss of consciousness.

GETTING STARTED

WHAT DOES IT MEAN?

Many of the terms used in describing health cost-sharing may be unfamiliar to those new to the programs and plans provided by Aliera and Trinity. Please refer to the Definition of Terms section for a quick and easy understanding of terms used in this guide and other plan documents.

1. **Activate Your Membership**
   On or after your effective date, visit **www.alierahealthcare.com** to securely enter your information. Click the Activation tab on the navigation bar and follow the instructions. **If you require assistance, contact a Member Care Specialist toll-free at (844) 834-3456 or email memberservices@alierahealthcare.com.**



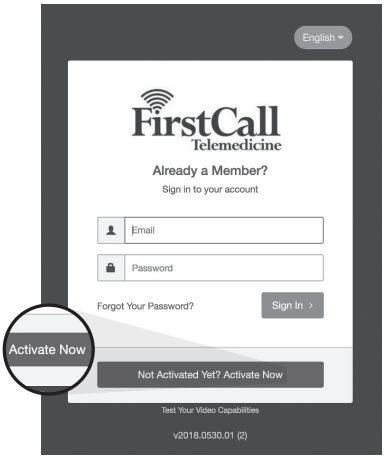
2. Set Up Your Telemedicine Account

Follow the steps below to set up your telemedicine account. If you have not activated your Membership Card, or if your Membership fees are not paid up to date, you are not eligible to set up your telemedicine account.

- Set up your account (Primary Member)
  Visit **www.firstcalltelemed.com,** Click "Activate Now." Follow the online instructions and provide the required information, including your medical history.

- Set up minor dependents (17 years or younger)
  Log in to your account and click "My Family" on the top menu. Follow the online instructions to provide the necessary information and complete your dependent's medical history.

- Set up adult dependents (18 – 26 years)
  Adult dependents must set up their own account. Visit the website and click "Set up account." Follow the online instructions to provide the required information and to complete your medical history.



3. **Set Up Your Prescription Discount Account**
   Follow the steps below to set up your prescription discount account. If you have not activated your Membership Card, or if your Membership fees are not paid up to date, you are not eligible to set up your prescription discount account.

   Please go to **www.myrxvalet.com/memberlogin.php**

   1. Enter your Member ID that is located on your Aliera Healthcare ID card
   2. For your Group ID type in Aliera
   3. Complete your profile for yourself and any dependents

   After registration is complete, you will receive an email with instructions and a video on how to use Rx Valet for home delivery and at your local pharmacy.

   Please download the Rx Valet APP on your smartphone at your convenience.

   If you are experiencing an urgent situation and don't have time to set up your account, you can hand your Aliera card to the pharmacist to receive your medication. The discount will not be as great, so please set up your account when you have time.

   Home Delivery Prescription Information:

   - Home Delivery orders are fulfilled exclusively through Advanced Pharmacy, LLC. To save time, have your physician send your prescription directly to Advanced Pharmacy electronically.
   - Alternatively, they can also transfer your existing prescriptions from another pharmacy to fulfill your order. Please call their live Customer Care Team at 1-855-798-2538 and provide the medication details, pharmacy name, and pharmacy telephone number.
   - Electronic prescriptions should be sent to Advanced Pharmacy, LLC located at **350-D Feaster Road Greenville, SC 29615**.
     Phone: 855-240-9368 **Fax: 888-415-7906**
     NPI: 1174830475 **NCPDP: 4229971**

4. **Review Your Offerings**
   This guide contains the information you need to understand each offering available with your Plan. Keep your Member Card with you at all times; the contact number for your telemedicine provider is printed on your card. It is highly encouraged to contact your telemedicine provider before seeking medical attention.

TELEMEDICINE

More than 80% of primary medical conditions can be resolved by your telemedicine provider. It is always encouraged that members contact their telemedicine provider first for quick, convenient medical assistance. The contact information for your telemedicine provider is found on your member card. Instructions are also found on the back of your Welcome Letter, as well as on our web site, under Member Resources.

Offerings of the Telemedicine Program

- At home, at work, or while traveling in the US, speak to a telemedicine doctor from anywhere, anytime, on the go.
- 24/7 access to a doctor via face-to-face internet consultation or by phone is available for you and dependents on your Plan.
- Speak with the next available doctor or schedule an appointment for a more convenient time.
- Telemedicine doctors typically respond within 15 minutes of your call.
- Save time and money by avoiding expensive emergency room visits, waiting for an appointment, or driving to a local facility.
- Telemedicine consultations are free for you and dependents on your Plan.
- Telemedicine providers can treat conditions such as:
  - Cold and flu symptoms
  - Bronchitis
  - Allergies
  - Poison ivy
  - Pink eye
  - Urinary tract infections
  - Respiratory infections
  - Sinus problems
  - Ear infections, and more

Antibiotics are not always the answer to treat a medical condition. Doctors may choose not to prescribe antibiotics for viral illnesses such as common colds, sore throats, coughs, sinus infections, and the flu.

If the telemedicine doctor recommends that you see your PCP or visit an urgent care facility, contact Aliera's Concierge Service, and a member care specialist will be happy to assist you with scheduling an appointment.

PREVENTIVE CARE

It's easier to stay healthy when you have regular preventive care. Members have no out-of-pocket expenses for preventive services, which include, but are not limited to, routine in-network checkups, pap smears, flu shots and more.

HOW TO USE PREVENTIVE CARE SERVICES

1. Download the Preventive Healthcare Guidebook from the link found in your Welcome email or visit us online at **www.alierahealthcare.com** or **www.trinityhealthshare.org**.

2. Members do not need to call their telemedicine provider to schedule preventive care.

3. Upon arrival at a PCP, please present your Membership Card and one photo ID. The front desk admin will check your eligibility status. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not share the costs of the provider.

4. Preventive health services must be appropriate for the eligible person and follow the guidelines below:

   A. In general – those of the U.S. Preventive Services Task Force that have an A or B rating.

   B. For immunizations – those of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

   C. For preventive care and screenings for children and adolescents – those of the Health Resources and Services Administration.

   D. For preventive care and screenings for women – those of the Health Resources and Services Administration that are not included in section (A) of the U.S. Preventive Services Task Force schedule.

LABS AND DIAGNOSTICS

Aliera and Trinity Members have access to lab work in the convenience of their in-network provider's office or at any lab location nationwide.

URGENT CARE

Your membership raises the standard of healthcare available to you by putting individuals first, treating them with clinical excellence, and focusing on their well-being. Members can access services from hundreds of Urgent Care network facilities throughout the United States.

- Plans vary, and can provide up to two (2) visits, where consult fee may apply.
- See Appendix for your specific plan details
- X-rays are included, and subject to $25 per read fee at Urgent Care.

HOW TO USE THE URGENT CARE SERVICE

1. Call 911 if your emergency is life threatening; otherwise, please contact your telemedicine provider first via telephone or a scheduled face-to-face internet conference. Your provider will determine if your medical condition can be resolved without visiting a local Urgent Care facility.
2. If your medical issue cannot be resolved after your free consultation with a telemedicine doctor, visit the closest in-network Urgent Care facility.
3. Upon arrival at an Urgent Care facility, present your Membership Card and one photo ID. The front desk admin will check your eligibility status. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the provider.
4. At time of service, payment of $20 (on average) is due for the consultation, and a $25 per read fee for X-rays if needed may be due. Costs may be higher depending on your state and provider.

IF URGENT CARE SERVICES ARE UNAVAILABLE

If an in-network Urgent Care facility is unavailable to a Member requiring immediate Urgent Care, please adhere to the following procedure:

1. Visit **www.alierahealthcare.com**. Click “Network” to find the nearest Urgent Care facility under MultiPlan.

2. If the nearest in-network facility is more than 20 miles away from the Member, is closed (after 6:00 p.m.), or is no longer in business, the Member should seek out the nearest urgent care facility, hospital, or emergency room to receive urgent medical attention.

3. AlieraCare products are not health insurance plans and Aliera nor Trinity are responsible for payment to out-of-network urgent care facility, hospital, or emergency room. The Member is solely responsible for such Urgent Care medical payments. Aliera and or Trinity maintain an allotment fund designed to provide a Member with supplemental payment assistance (ex gratia) in the amount of $105.00 to offset the cost incurred at an out-of-network Urgent Care or Hospital Emergency Room facility. This monetary assistance is limited to one visit per year, per Member. Payment is made directly to the Member after confirmation of submitted proof of Urgent Care necessity and unavailability of an in-network provider.

PRIMARY CARE

PRIMARY CARE FOR SICK CARE

In addition to our Urgent Care services, many of our plans offer Members under the age of 65 episodic primary care or sick care.

- Plans with annual PCP visits include one (1), three (3), or five (5) visits, each with consult fee ranging from $20 to $40 in certain markets.
- For convenience, some clinics are open evenings and weekends.

HOW TO USE PRIMARY CARE SERVICE FOR SICK CARE

1. Contact your telemedicine provider to speak with a U.S. board-certified doctor via telephone or a scheduled face-to-face internet conference.
2. The telemedicine doctor may be able to resolve your medical issue and prescribe medication if needed. More than 80% of primary medical conditions can be resolved by your telemedicine provider.
3. If your medical issue cannot be resolved after no fee consultation with the telemedicine doctor, visit the closest in-network Primary Care facility.
4. Upon arrival at a clinic, present your Membership Card and one photo ID. The front desk admin will check your eligibility status before you can see a provider. If you have not activated your Membership Card, or if Membership fees are not current, your Plan will not cover the costs of the provider.
5. At the time of service, a payment of $20 (on average) is due for the consultation, and a $25 per read fee for X-rays if needed. Costs may be higher depending on your state and provider.

SPECIALTY CARE

AlieraCare Premium members are required to obtain referrals to visit a specialist, except for women in need of gynecological care for routine medical needs. Specialty visits have a consult fee of $75 and the member has full responsibility of the bill until their Member Shared Responsibility Amount (MSRA) has been met. After MSRA is met, Specialty visits only have the cost of the $75 consult fee.

HOSPITALIZATION

Your hospitalization cost-sharing is provided to you in an effort to alleviate the stress and strain during times of crisis or medical needs.

1. Members are required to pre-authorize all hospitalization services and visits unless it is an obvious medical emergency. Please see pre-authorization section for instructions.

2. The member will be responsible for first reaching their MSRA before any cost-sharing will be available. Once the MSRA has been reached in full, the sharing will then be reimbursed directly back to the providers and hospital facilities.

3. Several plans allow for fixed cost-sharing in the emergency room. Please see Appendix for your exact plan details.

PPO NETWORK

With a growing nationwide PPO network of more than 1,000,000 healthcare professionals and more than 6,000 facilities, Multiplan PHCS network offers Plan Members a range of quality choices to help them stay healthy.

- Search for providers by distance, cost efficiency, and specialty.

FIND A NETWORK HEALTHCARE PROFESSIONAL

- Visit **www.alierahealthcare.com**.
- Hover over the Member Resources tab.
- Click on Provider Network.
- Click on the Medical Provider logo associated with your plan.
- Search for a provider by Zip Code, City, County, State, or other search criteria.

Call Aliera Healthcare at (844) 834-3456 OR
Trinity HealthShare at (844) 763-5338.

Select the Provider Coordination Department and a care coordinator will help you navigate the healthcare process effectively and efficiently.

PART II : HOW YOUR HEALTHCARE COST-SHARING MINISTRY (HCSM) WORKS

Trinity HealthShare is a clearing house that administers voluntary sharing of healthcare needs for qualifying members. The membership is based on a tradition of mutual aid, neighborly assistance, and burden sharing. The membership does not subsidize self-destructive behaviors and lifestyles, but is specifically tailored for individuals who maintain a healthy lifestyle, make responsible choices in regards to health and care, and believe in helping others. The Trinity HealthShare membership is not health insurance.

Guidelines Purpose and Use

The HCSM guidelines are provided as an outline for eligible needs in which contributions are shared in accordance with the membership's clearing house instructions. They are not for the purpose of describing to potential contributors the amount that will be shared on their behalf and do not create a legally enforceable right on the part of any contributor. Neither these guidelines nor any other arrangement between contributors and Trinity HealthShare creates any rights for any contributor as a reciprocal beneficiary, as a third-party beneficiary, or otherwise.

The edition of the guidelines in effect, on the date of medical services, supersedes all previous editions of the guidelines and any other communication, written or verbal. With written notice to the general membership, the guidelines may change at any time based on the preferences of the membership and on the decisions, recommendations, and approval of the Board of Trustees.

An exception to a specific provision only modifies that provision and does not supersede or void any other provisions.

Individuals Helping Individuals

Contributors participating in the membership help individuals with their medical needs. Trinity HealthShare facilitates in this assistance and acts as an independent and neutral clearing house, dispersing monthly contributions as described in the membership instructions and guidelines.

MEMBERSHIP QUALIFICATIONS

To become and remain a member of Trinity HealthShare, a person must meet the following criteria:

Religious Beliefs and Standards. The person must have a belief of helping others and/or maintaining a healthy lifestyle as outlined in the Statement of Beliefs contained in the membership application. If at any time during participation in the membership, the individual is not honoring the Statement of Beliefs, they will be subject to removal from participating in the membership.

Medical History. The person must meet the criteria to be qualified for a membership on his/her application date, based on the criteria set forth in this guidebook and the membership application.

If, at any time, it is discovered that a member did not submit a complete and accurate medical history on the membership application, the criteria set forth in the Membership Eligibility Manual on his/her application date will be applied, and could result in either a retroactive membership limitation or a retroactive denial to his/her effective date of membership.

Members may apply to have a membership limitation removed by providing medical evidence that they qualify for such removal according to the criteria set forth in the Membership Eligibility Manual. Membership limitations and denials can be applied retroactively but cannot be removed retroactively.

Application, Acceptance, and Effective Date. A person must submit a membership application and be accepted into the membership by meeting the criteria of the Member Eligibility Manual. The membership begins on a date specified by Trinity HealthShare in writing to the member.

Dependent(s). A dependent may participate under a combined membership with the head of household.

A dependent wishes to continue participating in the membership but no longer qualifies under a combined membership must apply and qualify for a membership based on the criteria set forth in the Membership Eligibility Manual.

Under a combined membership, the head of household is responsible for ensuring that everyone participating under the combined membership meets and complies with the Statement of Beliefs and all guideline provisions.

Financial Participation. Monthly contributions are requested to be received by the 1st or 15th of each month depending on the member's effective date. If the monthly contribution is not received within 5 days of the due date, an administrative fee may be assessed to track, receive, and post the monthly contribution. If the monthly contribution is not received by the end of the month, a membership will become inactive as of the last day of the month in which a monthly contribution was received.

Any member who has a membership that has become inactive will be able to reapply for membership under the terms outlined to them in writing by Trinity HealthShare. A member will not be able to reapply for membership if their account has been made inactive a total of three times.

Needs occurring after a member's inactive date and before they reapply are not eligible for sharing.

When Available Shares are less than Eligible Needs. In any given month, the available suggested share amounts may or may not meet the eligible needs submitted for sharing. If a member's eligible bills exceed the available shares to meet those needs, the following actions may be taken:

1. A pro-rata sharing of eligible needs may be initiated, whereby the members share a percentage of eligible medical bills within that month and hold back the balance of those needs to be shared the following month.

2. If the suggested share amount is not adequate to meet the eligible needs submitted for sharing over a 60-day period, then the suggested share amount may be increased in sufficient proportion to satisfy the eligible needs. This action may be undertaken temporarily or on an ongoing basis.

Other Criteria. Children under the age of 18 may not qualify for their own membership. Non-U.S. citizens may qualify for membership as determined by Trinity HealthShare on a case-by-case basis.

MONTHLY CONTRIBUTIONS

Monthly contributions are voluntary contributions or gifts that are non-refundable. As a non-insurance membership, neither Trinity HealthShare nor the membership are liable for any part of an individual's medical need. All contributors are responsible for their own medical needs. Although monthly contributions are voluntary contributions or gifts, there are administrative costs associated with monitoring the receipt and disbursement of such contributions or gifts. Therefore, declined credit cards, returned ACH payments, or any contribution received after the members reoccurring active date may incur an administrative fee.

IMPORTANT INFORMATION ABOUT PLAN CHANGES:

Members wishing to change to a membership type other than that which they are currently participating may, at the discretion of Trinity HealthShare, be required to submit a new signed and dated membership application for review. Membership type changes can only become effective on the first of the month after the new membership application has been approved.

1. When switching from one annual product category to another (i.e. AlieraCare to Trinity HealthShare's CarePlus Advantage) your plan will be reset as if it is a new enrollment. This rule does not apply when transitioning from an InterimCare plan.

2. You are allowed two plan changes per membership year. The first is free of cost, the second will incur the application fee of the desired product.

Contributors wishing to discontinue participation in the membership must submit the request in writing by the 20th day of the month before which the contributions will cease. The request should contain the reason why the contributor is discontinuing participation in the membership. Should the contributor fail to follow these guidelines as they pertain to discontinuing their participation in the membership and later wish to reinstate their membership, unsubmitted contributions from the prior participation must be submitted with a new application.

A member is not eligible for cost-sharing when a member:

A. Receives care within the first 60 days of the plan and cancels membership within 30 days of receiving medical care, except within the last 90 days of the membership term.

B. Receives or requires surgery within the first 60 days of becoming a member except in the case of an accident.

EARLY VOLUNTARY TERMINATION

Members of the Trinity HealthShare may terminate their membership at any time, with 30 days prior notice. Trinity HealthShare plans are not a substitute for "short term medical plans." Medical expenses incurred during the term of the membership and followed by early voluntary termination within 90 days of incurring medical expenses, will be reviewed and may not be eligible for cost-sharing, where the early termination was not as a direct result of affordability issues with the health sharing program.

STATEMENT OF BELIEFS

At the core of what we do, and how we relate to and engage with one another as a community of people, is a set of common beliefs. Our Statement of Shared Beliefs is as follows:

1. We believe that our personal rights and liberties originate from God and are bestowed on us by God.
2. We believe every individual has a fundamental religious right to worship God in his or her own way.
3. We believe it is our moral and ethical obligation to assist our fellow man when they are in need per our available resources and opportunity.
4. We believe it is our spiritual duty to God and our ethical duty to others to maintain a healthy lifestyle and avoid foods, behaviors, or habits that produce sickness or disease to ourselves or others.
5. We believe it is our fundamental right of conscience to direct our own healthcare in consultation with physicians, family, or other valued advisors.

DEFINITION OF TERMS

Terms used throughout the Member Quick Guide and other documents are defined as follows:

Affiliated Practitioner. Medical care professionals or facilities that are under contract with a network of providers with whom Trinity HealthShare works. Affiliated providers are those that participate in the PHCS network. A list of providers can be found at **http://www.multiplan.com.**

Application Date. The date Trinity HealthShare receives a complete membership application.

Combined Membership. Two or more family members residing in the same household.

Contributor. Person named as head of household under the membership.

Dependent. The head of household's spouse or unmarried child(ren), under the age of 20 or 26 if a full-time student, who are the head of household's dependent by birth, legal adoption, or marriage who is participating under the same combined membership.

Eligible. Medical needs that qualify for voluntary sharing of contributions from escrowed funds, subject to the sharing limits.

Escrow Instructions. Instructions contained on the membership application outlining the order in which voluntary monthly contributions may be shared by Trinity HealthShare.

Guidelines. Provided as an outline for eligible medical needs in which contributions are shared in accordance with the membership's escrow instructions.

Head of Household. Contributor participating by himself for herself; or the husband or father that participates in the membership; or the wife or mother that participates in the membership. The Head of Household is the oldest member on the plan.

Licensed Medical Physician. An individual engaged in providing medical care and who has received state license approval as a practicing Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

Medically Necessary. A service, procedure, or medication necessary to restore or maintain physical function and is provided in the most cost-effective setting consistent with the member's condition. Services or care administered as a precaution against an illness or condition or for the convenience of any party are not medically necessary. The fact that a provider may prescribe, administer, or recommend services or care does not make it medically necessary, even if it is not listed as a membership limitation or an ineligible need in these guidelines. To help determine medical necessity, Trinity HealthShare may request the member's medical records and may require a second opinion from an affiliated provider.

Member(s). A person(s) who qualifies to receive voluntary sharing of contributions for eligible medical needs per the membership clearing house instructions, guidelines, and membership type.

Member Shared Responsibility Amounts (MSRA). The amounts of an eligible need that do not qualify for sharing because the member is responsible for those amounts.

Membership. All members of Trinity HealthShare.

Membership Eligibility Manual. The reference materials that contain the criteria used to determine if a potential member is eligible for participation in the membership and if any membership limitations apply.

Membership Type. HCSM sharing options are available with different member shared responsibility amounts (MSRA) and sharing limits as selected in writing on the membership application and approved by Trinity HealthShare.

Monthly Contributions. Monetary contributions, excluding the annual membership fee, voluntarily given to Trinity HealthShare to hold as an escrow agent and to disburse according to the membership escrow instructions.

Need(s). Charges or expenses for medical services from a licensed medical practitioner or facility arising from an illness or accident for a single member.

Non-affiliated Practitioner. Medical care professionals or facilities that are not participating within our current network.

Pre-existing Condition. Any illness or accident for which a person has been diagnosed, received medical treatment, been examined, taken medication, or had symptoms within 24 months prior to the effective date. Symptoms include but are not limited to the following: abnormal discharge or bleeding; abnormal growth/break; cut or tear; discoloration; deformity; full or partial body function loss; obvious damage, illness, or abnormality; impaired breathing; impaired motion; inflammation or swelling; itching; numbness; pain that interferes with normal use; unexplained or unplanned weight gain or loss exceeding 25% of the total body weight occurring within a six-month period; fainting, loss of consciousness, or seizure; abnormal results from a test administered by a medical practitioner.

Usual, Customary and Reasonable (UCR). The lesser of the actual charge or the charge most other providers would make for those or comparable services or supplies, as determined by Trinity HealthShare.

CONTRIBUTORS' INSTRUCTIONS AND CONDITIONS

By submitting monthly contributions, the contributors instruct Trinity HealthShare to share clearing house funds in accordance with the membership instructions. Since Trinity HealthShare has nothing to gain or lose financially by determining if a need is eligible or not, the contributor designates Trinity HealthShare as the final authority for the interpretation of these guidelines. By participation in the membership, the member accepts these conditions.

ELIGIBLE MEDICAL EXPENSES*

Medical costs are shared on a per person per incident basis for illnesses or injuries incurring medical expenses after the membership effective date when medically necessary and provided by or under the direction of licensed physicians, osteopaths, urgent care facilities, clinics, emergency rooms, or hospitals (inpatient and outpatient), or other approved providers. Unless otherwise limited or excluded by these Guidelines, medical expenses eligible for sharing include, but are not limited to, physician and hospital services, emergency medical care, surgical procedures, medical testing, x-rays, ambulance transportation, and prescriptions.

**See the Appendix for other limits and conditions of sharing by plan*

1. **Allergy Office Visits and Testing**

2. **Ambulance.** Emergency land or air ambulance transportation to the nearest medical facility capable of providing the medically necessary care to avoid seriously jeopardizing the sharing member's life or health. Air transportation is limited to $10,000.

3. **Anesthesiologist Services**

4. **Cancer.** Cancer sharing eligibility is different based on plan option chosen. AlieraCare plans have a 12 month wait period for cancer. Sharing is available the 1st day of the 13 month of continuous membership. Any pre-existing or recurring cancer condition is not eligible for sharing. Cancer sharing will not be available for individuals who have cancer at the time of or five (5) years prior to application. If cancer existed outside of the 5-year time frame of a pre-existing look-back, the following must be met in the five (5) years prior to application, to be eligible for future, non-recurring cancer incidents.

    A. The condition had not been treated nor was future treatment prescribed/planned;

    B. The condition had not produced harmful symptoms (only benign symptoms);

c. The condition had not deteriorated. Cancer is limited to a maximum per term of $500,000 when applicable.

5. **Cardiac Rehabilitation.** Eligible after MSRA

6. **Chemotherapy.** Subject to cancer limitations.

7. **Chronic Maintenance.** Chronic maintenance is eligible when a member has chosen a plan with chronic maintenance specifically included and a listing of the maximum number of allowable visits. See 'Appendix' attached hereto.

8. **Competitive Sports.** Plan holders who participate in organized and/or sanctioned competitive sports are eligible for $5,000 (max) of sharing per incident at an emergency room, subject to the member-shared responsibility amount.

9. **Emergency Room.** Emergency room services for stabilization or initiation of treatment of a medical emergency condition provided on an outpatient basis at a hospital, clinic, or Urgent Care facility, including when hospital admission occurs within twenty-three (23) hours of emergency room treatment.

10. **Eye Care.** Limited to medical necessity and accident only. Excludes cosmetic, frames, lenses, contacts, extensive eye exams and subject to pre-existing limitations.

11. **Hospitalization.** Hospital charges for inpatient or outpatient hospital treatment or surgery for a medically diagnosed condition.

12. **Labs & Diagnostics.** The membership includes over 180 different lab tests, at any lab facility, to ensure the member gets the medical care they need.

13. **Maternity.** Maternity medical expenses are only eligible for sharing in the Premium AlieraCare Plan, which offers sharing for medical expenses rendered for a natural delivery up to $5,000. Medical expenses for maternity ending in a delivery by emergency cesarean section that are medically necessary, are eligible for sharing up to $8,000 subject to the applicable Member Shared Responsibility Amount. Medical expenses for a newborn arising from complications at the time of delivery, including, but not limited to, premature birth, are treated as a separate incident and limited to $50,000 of eligible sharing, subject to the Member Shared Responsibility Amount. See the Appendix for specific sharing inclusions and limits for your plan choice.

14. **Mental Health.** Plan holders are eligible for $2,500 (max) for Psychotherapy office visits and $1,000 (max) at out-patient facilities. Excludes in-patient and residential settings.

15. **Occupational Therapy.** Up to six (6) visits per membership year for occupational therapy.

16. **Organ Transplant Limit.** Eligible needs requiring organ transplant may be shared up to a maximum of $150,000 per member. This includes all costs in conjunction with the actual transplant procedure. Needs requiring multiple organ transplants will be considered on a case-by-case basis.

17. **Physical Therapy.** Up to six (6) visits per membership year for physical therapy by a licensed physical therapist.

18. **Prescription Drugs.** The AlieraCare plan includes a service by RX Valet, which includes discounts for prescription drugs. See Appendix for details.

19. **Preventive.** Most programs from either Trinity HealthShare or Aliera provide everyone with the necessities of the 64 Preventive Care services as outlined by the United States Preventive Task force. (Excludes CarePlus Advantage.) Preventive Care includes the PCP office visit and does not require a co-expense or consult fee.

20. **Primary Care.** Depending on your plan choice, primary care is at the core of preventing medical issues from escalating into a more catastrophic need. See Appendix for the specific plan details.

21. **Radiation Therapy.** Subject to cancer limitations.

22. **Routine Hearing Exams.** At primary care (PCP) only.

23. **Sleep Disorders.** Overnight Sleep Testing Limit: All components of a polysomnogram must be completed in one session. A second overnight test will not be eligible for sharing under any circumstance. Overnight sleep testing must be medically necessary and will require pre-authorization. Allowed charges will not exceed the Usual, Customary, and Reasonable charges for the area.

24. **Smoking Cessation.** Members who have acknowledged they smoke and made an additional contribution are provided the opportunity to obtain free smoking cessation medication and counseling through the eligible preventive services.

25. **Specialty Care.** Specialty Care is included in the AlieraCare Premium plan. Specialty visits have a consult fee of $75 and the member has full responsibility of the bill until their Member Shared Responsibility Amount (MSRA) has been met. After MSRA is met, Specialty visits only have the cost of the $75 consult fee.

26. **Speech Therapy.** Up to six (6) visits per membership year. Only applicable after a stroke.

27. **Surgical Offerings.** Non-life-threatening surgical offerings are not available for the first 60 days of membership for Premium plans and all other plans require six (6) month wait period. Please verify eligibility by calling Members Services before receiving any surgical services.

28. **Telemedicine.** Telemedicine is included in all AlieraCare programs offered by Trinity HealthShare and Aliera Healthcare as your first line of defense. Your membership provides you and your family 24/7/365 access to a U.S. Board certified medical doctor.

29. **Urgent Care.** If your plan provides cost-sharing for Urgent Care, you will have the added offering of enjoying the ability to choose an Urgent Care facility in lieu of an emergency room. See the Appendix for any Urgent Care options and any limitations to plan.

30. **X-rays.** X-rays listed on your plan details in the Appendix are for imaging services at PCP or Urgent Care facilities only and requires a $25 read fee per view at time of service. Your MSRA will apply to all other x-rays. MRI, CT Scans and other diagnostics must be paid with your MSRA before cost-sharing is provided.

**Medical Expense Incident is any medically diagnosed condition receiving medical treatment and incurring medical expenses of the same diagnosis. All related medical bills of the same diagnosis comprise the same incident. Such expenses must be submitted for sharing in the manner and form specified by Trinity HealthShare. This may include, but not be limited to, standard industry billing forms (HCFA1500 and/or UB 92) and medical records. Members share these kinds of costs.*

LIMITS OF SHARING

Total eligible needs shared from member contributions are limited as defined in this section and as further limited in writing to the individual member.

1. **Lifetime Limits.** $1,000,000: the maximum amount shared for eligible needs over the course of an individual member's lifetime.

2. **Per Incident.** The occurrence of one particular sickness, illness, or accident.

3. **Cancer Limits when applicable.** Cancer is limited to a maximum per term of $500,000 when applicable.

4. **Member Shared Responsibility Amounts (MSRA).** The eligible amount that does not qualify for sharing based on the membership type chosen by the member.

5. **Office Visit/Urgent Care.** Office visits, in particular, primary and urgent, have certain limits and inclusions. Please refer to the Appendix for your specific plan.

6. **Non-Affiliated Practitioner.** Services rendered by a non-affiliated practitioner will not be eligible for sharing nor will any amount be applied to your MRSA unless specified differently in the plan details contained herein.

7. **Cost-Sharing for Pre-Existing Conditions.** Hospitalization, In-Patient and Out-Patient Surgery, Specialty Care, and Emergency Room services for pre-existing conditions have a 24-month waiting period. All other healthcare services for pre-existing conditions are eligible upon effective date.

Other Resources. Offerings available to the member from other sources such as insurance, VA, Tricare, private grants, or by a liable third party (primary, auto, home insurance, educational, etc.), will be considered the member's primary benefit source, and the member will be required to file medical claims with those providers first. If there are medical expenses that those sources do not pay, the member is authorized to submit the excess medical expenses for sharing, and the MSRA will be waived, up to the maximum MSRA as defined in the member's plan. The MSRA will only be waived if a third party source pays on the member's behalf. Sharing of monthly contributions for a need that is later paid, or found to payable by another source will automatically allow Trinity HealthShare full rights to recover the amounts that were shared with the member.

MEDICAL EXPENSES NOT GENERALLY SHARED BY HCSM

Only needs incurred on or after the membership effective date are eligible for sharing under the membership instructions. The member (or the member's provider) must submit a request for sharing in the manner and format specified by Trinity HealthShare. This includes, but is not limited to, a Need Processing Form, standard industry billing forms (HCFA 1500 and/or most recent UB form), and may include medical records. All participating members have a responsibility to abide by the Members' Rights and Responsibilities published by Trinity HealthShare and are included at the end of these guidelines.

Needs arising from any one of the following are not eligible for sharing under the membership clearing house instructions:

1. Abortion Services
2. Acupuncture Services
3. Aqua Therapy
4. B12 Injections
5. Biofeedback
6. Birth Control (Female)
7. Birth Control (Male) Elective Sterilization
8. Birth Control (Male) Reversal of Sterilization
9. Cataract Contacts or Glasses
10. Chemical Face Peels
11. Chiropractic Services
12. Christian Science Practitioner
13. Cochlear Devices
14. Cosmetic Surgery
15. Cost-Sharing for Pre-existing Conditions. Hospitalization, In-Patient and Out-Patient Surgery, Specialty Care, and Emergency Room services for pre-existing conditions have a 24-month waiting period. All other healthcare services for pre-existing conditions are eligible upon effective date.

16. Custodial Care Services
17. Dental Services
18. Dermabrasion Services
19. Diabetic Insulin, Supplies, and Syringes
20. Doula
21. Durable Medical Equipment
22. Education Services
23. Exercise Equipment
24. Experimental Drugs
25. Experimental Procedures
26. Extreme sports: Sports that voluntarily put an individual in a life-threatening situation. Sports such as but not limited to “free climb” rock climbing, parachuting, fighting, martial arts, racing, cliff diving, powerboat racing, air racing, motorcycle racing, extreme skiing, wing-suit, and similar.
27. Gender Dysphoria
28. Gender Dysphoria Office Visit – PCP
29. Gender Dysphoria Office Visit – Specialist
30. Genetic Testing
31. Group Therapy Services
32. Hemodialysis
33. Home Health Care
34. Home Infusion Services
35. Hospice Services
36. Hypnotherapy Services
37. Infertility Diagnostic or treatment

38. Infertility Services

39. Investigational Drugs/Procedures

40. Lifestyles or activities engaged in after the application date that conflicts with the Statement of Beliefs (on the membership application).

41. Massage Therapy

42. Midwifery

43. MILIEU Situational Therapy Services

44. Morbid Obesity

45. Non-Routine Hearing Exams & Hearing Aids

46. Nurse Practitioner

47. Orthopedic Shoes

48. Orthotics (back, neck, knee, wrist, etc.)

49. Pain Management

50. Personal aircraft includes hang gliders, parasails, ultra-lights, hot air balloons, sky/diving, and any other aircraft not operated by a commercially licensed public carrier.

51. Personal Convenience Items

52. Post-Surgical Bras

53. Podiatry Services

54. Preadmission Testing

55. Private Duty Nursing Services

56. Professional Sports Injuries

57. Prosthetic Appliances

58. Pulmonary Rehab

59. Robotic Surgery

60. Routine Nursery Care of Newborn Infant

61. Self-Inflicted Injury

62. Sexual Dysfunction Services

63. Sexual Transformation Services

64. Skilled Nursing Facility

65. Substance Abuse

66. Surgical Stockings

67. Treatment or referrals received or obtained from any family member including, but not limited to, father, mother, aunt, uncle, grandparent, sibling, cousin, dependent, or any in-laws.

PRE-AUTHORIZATION REQUIRED

Non-Emergency Surgery, Procedure, or Test. The member must have the following procedures or services pre-authorized as medically necessary prior to receiving the service. Failure to comply with this requirement will render the service not eligible for sharing.

Hospitalizations. Non-emergency prior to admission; emergency visits notification to Trinity HealthShare within 48 hours.

- MRI studies/CT scans/Ultrasounds
- Sleep studies must be completed in one session
- Physical or occupational therapy
- Speech therapy under limited circumstances only
- Cardiac testing, procedures, and treatments
- In-patient cancer testing, procedures, and treatments
- Infusion therapy within facility
- Nuclide studies
- EMG/EEG
- Ophthalmic procedures
- ER visits, emergency surgery, procedure, or test:
  Non-emergency use of the emergency room is not eligible for sharing. Trinity HealthShare must be notified of all ER visits within 48 hours. Medical records will be reviewed for all ER visits to determine eligibility. An emergency is defined as treatment that must be rendered to the patient immediately for the alleviation of the sudden onset of an unforeseen illness or injury that, if not treated, would lead to further disability or death. Examples of an emergency include, but are not limited to, severe pain, choking, major bleeding, heart attack, or a sudden, unexplained loss of consciousness.

Eligibility for Cancer Needs. In order for needs related to cancer hospitalization of any type to be eligible (e.g. breast, colorectal, leukemia, lymphoma, prostate, skin, etc.), the member must meet the following requirements:

The member is required to contact Trinity HealthShare within 30 days of diagnosis. If the member fails to notify Trinity HealthShare within the 30-day time frame, the member will be responsible for 50% of the total allowed charges after the MRSA(s) has been assessed to the member for in-patient cancer hospitalization.

Early detection provides the best chance for successful treatment and in the most cost effective manner. Effective January 1, 2017, the membership requires that all members aged 40 and older receive appropriate screening tests every other year – mammogram or thermography and pap smear with pelvic exams for women and PSA testing for men. ***Failure to obtain biannual mammograms and gynecological tests listed above for women or PSA tests for men will render future needs for breast, cervical, endometrial, ovarian, or prostate cancer ineligible for sharing.***

DISPUTE RESOLUTION AND APPEAL

Trinity HealthShare is a voluntary association of like-minded people who come together to assist each other by sharing medical expenses. Such a sharing and caring association does not lend itself well to the mentality of legally enforceable rights. However, it is recognized that differences of opinion will occur, and that a methodology for resolving disputes must be available. Therefore, by becoming a Sharing Member of Trinity HealthShare you agree that any dispute you have with or against Trinity HealthShare its associates, or employees will be settled using the following steps of action, and only as a course of last resort.

If a determination is made with which the sharing member disagrees and believes there is a logically defensible reason why the initial determination is wrong, then the sharing member may file an appeal.

A. **1st Level Appeal.** Most differences of opinion can be resolved simply by calling Trinity HealthShare who will try to resolve the matter telephonically within a reasonable amount of time.

B. **2nd Level Appeal.** If the sharing member is unsatisfied with the determination of the member services representative, then the sharing member may request a review by the Internal Resolution Committee, made up of three Trinity HealthShare officials. The appeal must be in writing, stating the elements of the dispute and the relevant facts. Importantly, the appeal should address all of the following:

1. What information does Trinity HealthShare have that is either incomplete or incorrect?
2. How do you believe Trinity HealthShare has misinterpreted the information already on hand?
3. Which provision in the Trinity HealthShare Guidelines do you believe Trinity HealthShare applied incorrectly?

Within thirty (30) days, the Internal Resolution Committee will render a written decision, unless additional medical documentation is required to make an accurate decision.

C. **3rd Level Appeal.** Should the matter remain unresolved, then the aggrieved party may ask that the dispute be submitted to three sharing members in good standing and randomly chosen by Trinity HealthShare, who shall agree to review the matter and shall constitute an External Resolution Committee. Within thirty (30) days the External Resolution Committee shall render their opinion in writing, unless additional medical documentation is required to make an accurate decision.

D. **Final Appeal.** If the aggrieved sharing member disagrees with the conclusion of his/her fellow sharing members, then the aggrieved party may ask that the dispute be submitted to a medical expense auditor, who shall have the matter reviewed by a panel consisting of personnel who were not involved in the original determination and who shall render their opinion in writing within thirty (30) days, unless additional medical documentation is required to make an accurate decision.

E. **Mediation and Arbitration.** If the aggrieved sharing member disagrees with the conclusion of the Final Appeal Panel, then the matter shall be resolved by first submitting the disputed matter to mediation. If the dispute is not resolved the matter will be submitted to legally binding arbitration in accordance with the Rules and Procedure of the American Arbitration Association. Sharing members agree and understand that these methods shall be the sole remedy to resolve any controversy or claim arising out of the Sharing Guidelines, and expressly waive their right to file a lawsuit in any civil court against one another for such disputes; except to enforce an arbitration decision. Any arbitration shall be held in Atlanta, Georgia, and conducted in the English language subject to the laws of the State of Georgia. Trinity HealthShare shall pay the filing fees for the arbitration and arbitrator in full at the time of filing. All other expenses of the arbitration shall be paid by each party including costs related to transportation, accommodations, experts, evidence gathering, and legal counsel. Further agreed that the aggrieved sharing member shall reimburse the full costs associated with the arbitration, should the arbitrator render a judgment in favor of Trinity HealthShare and not the aggrieved sharing member.

The aggrieved sharing member agrees to be legally bound by the arbitrator's final decision. The parties may alternatively elect to use other professional arbitration services available in the Atlanta metropolitan area, by mutual agreement.

APPENDIX A: PLAN DETAILS VALUE

1. Non-emergency surgical services are unavailable for the first 6 months for Value. Surgical services do not include cosmetic surgery.

2. Hospitalization, In-Patient and Out-Patient Surgery, Specialty Care, and Emergency Room services for pre-existing conditions have a 24 month waiting period. All other healthcare services for pre-existing conditions are eligible upon effective date.

3. Eligibility for cancer conditions is provided after 12 months of continuous membership, if a pre-existing cancer condition did not exist prior to or at the time of application.

4. The consult fee is in addition to the cost of your specialty visit and does not apply toward your annual MSRA.

5. Maternity services are unavailable for the first 10 months of membership.

6. ER visits are subject to review, and are meant only for life threatening situations. Maximum out-of-pocket is the full MSRA for the Value plan.

Trinity HealthShare, Inc. plans follow medical eligibility review protocols described in the plan but are not a promise to pay. Sharing is available for all eligible medical needs.

Administrative and Conditional Fees: $125 one-time application fee per enrollment. Add $60 for persons who smoke. Add $130 per member for additional $500,000 per incident.

* Annual physicals are available immediately at the cost of a Primary Care (PCP) visit. An inclusive annual physical is only available after 9 months of continual membership; lifestyle lab testing not included

** $25 per x-ray read fee at Urgent Care, (may vary by city)

APPENDIX A: PLAN DETAILS VALUE PLAN

	Multiplan PHCS	
Plan Services[1]	Network	Non-Network
Eligible prior to meeting Member Shared Responsibility Amount (MSRA)		
Wellness and Preventive Care	100%	N/A
Telemedicine	100%	N/A
Primary Care	1 per year* $20 Consult Fee	N/A
Urgent Care	N/A	N/A
Labs & Diagnostics	Preventive Only	N/A
X-Rays**	Preventive Only	N/A
Chronic Maintenance	N/A	N/A
Pediatrics	Preventive Only	N/A
OB/GYN	Preventive Only	N/A
Prescription Discount	Included	N/A
Eligible after meeting Member Shared Responsibility Amount (MSRA) [2,3]		
MSRA Options – Per member	$5,000, $7,500, $10,000	N/A
Per Incident Maximum Limit	$150,000	N/A
Lifetime Maximum Limit	$1,000,000	N/A
Specialty Care[4]	N/A	N/A
Maternity[5]	N/A	N/A
Hospitalization	Included	N/A
In-Patient Surgery	Included	N/A
Out-Patient Surgery	Included	N/A
Emergency Room[6]	Full MSRA	N/A

See Legal Appendix on page 36

APPENDIX B: PLAN DETAILS PLUS

1. Non-emergency surgical services are unavailable for the first 6 months for Plus. Surgical services do not include cosmetic surgery.

2. Hospitalization, In-Patient and Out-Patient Surgery, Specialty Care, and Emergency Room services for pre-existing conditions have a 24 month waiting period. All other healthcare services for pre-existing conditions are eligible upon effective date.

3. Eligibility for cancer conditions is provided after 12 months of continuous membership, if a pre-existing cancer condition did not exist prior to or at the time of application.

4. The consult fee is in addition to the cost of your specialty visit and does not apply toward your annual MSRA.

5. Maternity services are unavailable for the first 10 months of membership.

6. ER visits are subject to review, and are meant only for life threatening situations. Maximum out-of-pocket is $500 for the Plus plan.

Trinity HealthShare, Inc. plans follow medical eligibility review protocols described in the plan but are not a promise to pay. Sharing is available for all eligible medical needs.

Administrative and Conditional Fees: $125 one-time application fee per enrollment. Add $60 for persons who smoke. Add $130 per member for additional $500,000 per incident.

* Annual physicals are available immediately at the cost of a Primary Care (PCP) visit. An inclusive annual physical is only available after 9 months of continual membership; lifestyle lab testing not included

** $25 per x-ray read fee at Urgent Care, (may vary by city)

APPENDIX B: PLAN DETAILS PLUS PLAN

	Multiplan PHCS	
Plan Services[1]	Network	Non-Network
Eligible prior to meeting Member Shared Responsibility Amount (MSRA)		
Wellness and Preventive Care	100%	N/A
Telemedicine	100%	N/A
Primary Care	3 per year* $20 Consult Fee	N/A
Urgent Care	1 per year $20 Consult Fee	N/A
Labs & Diagnostics	PCP & Urgent Care	N/A
X-Rays**	100%**	N/A
Chronic Maintenance	N/A	N/A
Pediatrics	Preventive Only	N/A
OB/GYN	Preventive Only	N/A
Prescription Discount	Included	N/A
Eligible after meeting Member Shared Responsibility Amount (MSRA) [2,3]		
MSRA Options – Per member	$5,000, $7,500, $10,000	N/A
Per Incident Maximum Limit	$250,000	N/A
Lifetime Maximum Limit	$1,000,000	N/A
Specialty Care[4]	N/A	N/A
Maternity[5]	N/A	N/A
Hospitalization	Included	N/A
In-Patient Surgery	Included	N/A
Out-Patient Surgery	Included	N/A
Emergency Room[6]	$500 MSRA	N/A

See Legal Appendix on page 38

APPENDIX C: PLAN DETAILS PREMIUM

1. Non-emergency surgical services are unavailable for the first 2 months for Premium. Surgical services do not include cosmetic surgery.

2. Hospitalization, In-Patient and Out-Patient Surgery, Specialty Care, and Emergency Room services for pre-existing conditions have a 24 month waiting period. All other healthcare services for pre-existing conditions are eligible upon effective date.

3. Eligibility for cancer conditions is provided after 12 months of continuous membership, if a pre-existing cancer condition did not exist prior to or at the time of application.

4. The consult fee is in addition to the cost of your specialty visit and does not apply toward your annual MSRA.

5. Maternity services are unavailable for the first 10 months of membership.

6. ER visits are subject to review, and are meant only for life threatening situations. Maximum out-of-pocket is $300 for the Premium plan.

Trinity HealthShare, Inc. plans follow medical eligibility review protocols described in the plan but are not a promise to pay. Sharing is available for all eligible medical needs.

Administrative and Conditional Fees: $125 one-time application fee per enrollment. Add $60 for persons who smoke. Add $130 per member for additional $500,000 per incident.

* Annual physicals are available immediately at the cost of a Primary Care (PCP) visit. An inclusive annual physical is only available after 9 months of continual membership; lifestyle lab testing not included

** $25 per x-ray read fee at Urgent Care, (may vary by city)

APPENDIX C: PLAN DETAILS PREMIUM PLAN

	Multiplan PHCS	
Plan Services[1]	Network	Non-Network
Eligible prior to meeting Member Shared Responsibility Amount (MSRA)		
Wellness and Preventive Care	100%	N/A
Telemedicine	100%	N/A
Primary Care	5 per year* $20 Consult Fee	N/A
Urgent Care	2 per year $20 Consult Fee	N/A
Labs & Diagnostics	PCP & Urgent Care	N/A
X-Rays**	100%**	N/A
Chronic Maintenance	Included with PCP	N/A
Pediatrics	As Primary Care	N/A
OB/GYN	As Primary Care	N/A
Prescription Discount	Included	N/A
Eligible after meeting Member Shared Responsibility Amount (MSRA) [2,3]		
MSRA Options – Per member	$5,000, $7,500, $10,000	N/A
Per Incident Maximum Limit	$500,000	N/A
Lifetime Maximum Limit	$1,000,000	N/A
Specialty Care[4]	$75 Consult Fee (100% after MSRA)	N/A
Maternity[5]	$5,000 Max	N/A
Hospitalization	Included	N/A
In-Patient Surgery	Included	N/A
Out-Patient Surgery	Included	N/A
Emergency Room[6]	$300 MSRA	N/A

See Legal Appendix on page 40

APPENDIX D: TERMS, CONDITIONS, & SPECIAL CONSIDERATIONS

1. The Welcome Kit you received electronically includes this Quick Guide, your Membership Card(s), a Welcome Letter, and important information to activate your membership.

2. Keep your Membership Card with you at all times to present to a provider to confirm eligibility.

3. The ACA is subject to change at any time; Aliera reserves the right to adhere to those changes without notice to the Member.

4. Activate your Plan Membership by following the instructions in this Quick Guide.

5. Set up your telemedicine account by following the instructions on the Welcome Letter. Within three weeks of enrollment in Aliera's telemedicine partnering company, Members receive ID Card(s) for the telemedicine service along with instructions on how to utilize the service.

6. Telemedicine phone consultations are available 24/7/365, with face-to-face internet consultations available between the hours of 7 a.m. and 9 p.m., Monday – Friday.

7. Telemedicine does not guarantee that a prescription will be written.

8. Telemedicine does not prescribe DEA-controlled substances, non-therapeutic drugs, and certain other drugs which may be harmful because of their potential for abuse. Telemedicine doctors reserve the right to deny care for potential misuse of services.

9. Durable Medical Equipment (DME) – i.e. crutches, etc. – is not included in your Plan. Members will be charged for DME at time of service.

10. Member Care Specialists are available to assist you, Monday through Friday, 8 a.m. to 8 p.m. ET at (844) 834-3456. If you call after hours, follow the prompts.

11. At the time of service, payment of $20 (on average) is due for the consultation, and a $25 per read fee for X-rays at PCP or Urgent Care if needed. Consult fees vary in different states and may be higher in some cities, including but not limited to, New York City, Chicago, Detroit, Miami, Sacramento, Los Angeles, and San Francisco.

12. Plans may vary from state to state. Providers may be added or removed from Aliera's network at any time without notice.

13. Not all geographical areas are serviced by Aliera Healthcare. Should a Member visit an emergency room because urgent care facilities are unavailable in the Member's area, Aliera offers a one-time, once-a-year, $105 credit (ex gratia) to the Member to help offset the costs incurred.

14. Aliera telemedicine partners do not replace the Primary Care Provider.

15. Primary Care is defined as "episodic primary care" or "sick care." Members are responsible for paying a consult fee at the time of service; no consult fee is due for preventive service.

16. Most network facilities are able to accommodate both urgent care and primary care needs.

17. Not all PPO providers accept an AlieraCare plan. While Aliera offers one of the largest PPO networks in the country, some providers may not participate.

DISCLOSURES

1. Aliera Healthcare, the Aliera Healthcare logo, and other plan or service logos are trademarks of Aliera Healthcare, Inc. and may not be used without written permission.

2. Aliera and Trinity programs are NOT insurance. Aliera Healthcare, Inc./ Trinity HealthShare does not guarantee the quality of services or products offered by individual providers. Members may change providers upon 30 days' notice if not satisfied with the medical services provided.

3. Aliera's Healthcare Plans offer services only to Members and dependents on your Plan.

4. Aliera reserves the right to interpret the terms of this membership to determine the level of medical services received hereunder.

5. This membership is issued in consideration of the Member's application and the Member's payment of a monthly fee as provided under these Plans. Omissions and misstatements, or incorrect, incomplete, fraudulent, or intentional misrepresentation to the assumed risk in your application may void your membership, and services may be denied.

ABBREVIATIONS

ACA	Affordable Care Act (Obamacare)
CMS	Centers for Medicare and Medicaid Services
DEA	Drug Enforcement Administration
DME	Durable Medical Equipment
DPCMH	Direct Primary Care Medical Home Plans
HCSM	Health Care Sharing Ministry
MEC	Minimum Essential Coverage
PCP	Primary Care Provider
PPO	Participating Provider Organization
UC	Urgent Care

APPENDIX E: LEGAL NOTICES

The following legal notices are the result of discussions by Trinity HealthShare or other healthcare sharing ministries with several state regulators and are part of an effort to ensure that Sharing Members understand that Trinity HealthShare is not an insurance company and that it does not guarantee payment of medical costs. Our role is to enable self-pay patients to help fellow Aliera members through voluntary financial gifts.

GENERAL LEGAL NOTICE

This program is not an insurance company nor is it offered through an insurance company. This program does not guarantee or promise that your medical bills will be paid or assigned to others for payment. Whether anyone chooses to pay your medical bills will be totally voluntary. As such, this program should never be considered as a substitute for an insurance policy. Whether you receive any payments for medical expenses and whether or not this program continues to operate, you are always liable for any unpaid bills.

STATE SPECIFIC NOTICES

Alabama Code Title 22-6A-2

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Arizona Statute 20-122

Notice: the organization facilitating the sharing of medical expenses is not an insurance company and the ministry's guidelines and plan of operation are not an insurance policy. Whether anyone chooses to assist you with your medical bills will be completely voluntary because participants are not compelled by law to contribute toward your medical bills. Therefore, participation in the ministry or a subscription to any of its documents should not be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this ministry continues to operate, you are always personally responsible for the payment of your own medical bills.

Arkansas Code 23-60-104.2

Notice: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor plan of operation is an insurance policy. If anyone chooses to assist you with your medical bills, it will be totally voluntary because participants are not compelled by law to contribute toward your medical bills. Participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive a payment for medical expenses or if this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Florida Statute 624.1265

Trinity HealthShare is not an insurance company, and membership is not offered through an insurance company. Trinity HealthShare is not subject to the regulatory requirements or consumer protections of the Florida Insurance Code.

Georgia Statute 33-1-20

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Idaho Statute 41-121

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Illinois Statute 215-5/4-Class 1-b

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation constitute or create an insurance policy. Any assistance you receive with your medical bills will be totally voluntary. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Whether or not you receive any payments for medical expenses and whether or not this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Indiana Code 27-1-2.1

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor its plan of operation is an insurance policy. Any assistance you receive with your medical bills will be totally voluntary. Neither the organization nor any other participant can be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Whether or not you receive any payments for medical expenses and whether or not this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Kentucky Revised Statute 304.1-120 (7)

Notice: Under Kentucky law, the religious organization facilitating the sharing of medical expenses is not an insurance company, and its guidelines, plan of operation, or any other document of the religious organization do not constitute or create an insurance policy. Participation in the religious organization or a subscription to any of its documents shall not be considered insurance. Any assistance you receive with your medical bills will be totally voluntary. Neither the organization nor any participant shall be compelled by law to contribute toward your medical bills. Whether or not you receive any payments for medical expenses, and whether or not this organization continues to operate, you shall be personally responsible for the payment of your medical bills.

Louisiana Revised Statute Title 22-318,319

Notice: The ministry facilitating the sharing of medical expenses is not an insurance company. Neither the guidelines nor the plan of operation of the ministry constitutes an insurance policy. Financial assistance for the payment of medical expenses is strictly voluntary. Participation in the ministry or a subscription to any publication issued by the ministry shall not be considered as enrollment in any health insurance plan or as a waiver of your responsibility to pay your medical expenses.

Maine Revised Statute Title 24-A, §704, sub-§3

Notice: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. Participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Maryland Article 48, Section 1-202(4)

Notice: This publication is not issued by an insurance company nor is it offered through an insurance company. It does not guarantee or promise that your medical bills will be published or assigned to others for payment. No other subscriber will be compelled to contribute toward the cost of your medical bills. Therefore, this publication should never be considered a substitute for an insurance policy. This activity is not regulated by the State Insurance Administration, and your liabilities are not covered by the Life and Health Guaranty Fund. Whether or not you receive any payments for medical expenses and whether or not this entity continues to operate, you are always liable for any unpaid bills.

Mississippi Title 83-77-1

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment of medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Missouri Section 376.1750

Notice: This publication is not an insurance company nor is it offered through an insurance company. Whether anyone chooses to assist you with your medical bills will be totally voluntary, as no other subscriber or member will be compelled to contribute toward your medical bills. As such, this publication should never be considered to be insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always personally responsible for the payment of your own medical bills.

Nebraska Revised Statute Chapter 44-311

IMPORTANT NOTICE. This organization is not an insurance company, and its product should never be considered insurance. If you join this organization instead of purchasing health insurance, you will be considered uninsured. By the terms of this agreement, whether anyone chooses to assist you with your medical bills as a participant of this organization will be totally voluntary, and neither the organization nor any participant can be compelled by law to contribute toward your medical bills. Regardless of whether you receive payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills. This organization is not regulated by the Nebraska Department of Insurance. You should review this organization's guidelines carefully to be sure you understand any limitations that may affect your personal medical and financial needs.

New Hampshire Section 126-V:1

IMPORTANT NOTICE: This organization is not an insurance company, and its product should never be considered insurance. If you join this organization instead of purchasing health insurance, you will be considered uninsured. By the terms of this agreement, whether anyone chooses to assist you with your medical bills as a participant of this organization will be totally voluntary, and neither the organization nor any participant can be compelled by law to contribute toward your medical bills. Regardless of whether you receive payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills. This organization is not regulated by the New Hampshire Insurance Department. You should review this organization's guidelines carefully to be sure you understand any limitations that may affect your personal medical and financial needs.

North Carolina Statute 58-49-12

Notice: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor its plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be voluntary. No other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally liable for the payment of your own medical bills.

Pennsylvania 40 Penn. Statute Section 23(b)

Notice: This publication is not an insurance company nor is it offered through an insurance company. This publication does not guarantee or promise that your medical bills will be published or assigned to others for payment. Whether anyone chooses to pay your medical bills will be totally voluntary. As such, this publication should never be considered a substitute for insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always liable for any unpaid bills.

South Dakota Statute Title 58-1-3.3

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payments for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Texas Code Title 8, K, 1681.001

Notice: This health care sharing ministry facilitates the sharing of medical expenses and is not an insurance company, and neither its guidelines nor its plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the ministry or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this ministry continues to operate, you are always personally responsible for the payment of your own medical bills. Complaints concerning this health care sharing ministry may be reported to the office of the Texas attorney general.

The ministry will assign a recommended cost sharing amount to the membership each month (“Monthly Share Amount”). By submitting the Monthly Share Amount, you instruct the ministry to assign your contribution as prescribed by the Guidelines. Up to 40% of your member contribution goes towards the administration of this plan. Administration costs are not all inclusive of vendor costs, which could account for up to 32% of the member contribution (monthly recommended share amount). Contributions to the member “Share Box” will never be less than 28% of the member monthly recommended share amount.

Virginia Code 38.2-6300-6301

Notice: This publication is not insurance, and is not offered through an insurance company. Whether anyone chooses to assist you with your medical bills will be totally voluntary, as no other member will be compelled by law to contribute toward your medical bills. As such, this publication should never be considered to be insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always personally responsible for the payment of your own medical bills.

Wisconsin Statute 600.01 (1) (b) (9)

ATTENTION: This publication is not issued by an insurance company, nor is it offered through an insurance company. This publication does not guarantee or promise that your medical bills will be published or assigned to others for payment. Whether anyone chooses to pay your medical bills is entirely voluntary. This publication should never be considered a substitute for an insurance policy. Whether or not you receive any payments for medical expenses, and whether or not this publication continues to operate, you are responsible for the payment of your own medical bills.

This is NOT Insurance.

NOTES:

ALIERACARE™
VALUE | PLUS | PREMIUM

TRINITY HealthShare℠

PO Box 28220 Atlanta, GA 30358
Toll Free 844-834-3456
AlieraHealthcare.com

AlieraCare Plans Are NOT Insurance.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

NOELLE LeCANN, KRISTIN SELIMO, and TANIA FUNDUK, on behalf of themselves and others similarly situated,	)	
Plaintiffs,	)	**CIVIL ACTION NO. 1:20-CV-02429-AT**
vs.	)	
THE ALIERA COMPANIES, INC., formerly known as ALIERA HEALTHCARE, INC.,	)	
Defendant.	)	

DEFENDANT'S MEMORANDUM OF LAW IN SUPPORT OF ITS MOTION TO DISMISS, OR ALTERNATIVELY, TO COMPEL ARBITRATION

Robert H. Rutherford
Elizabeth B. Shirley
BURR & FORMAN LLP
420 North 20th Street
The Shipt Tower, Suite 3400
Birmingham, Alabama 35203
Telephone: (205)251-3000
Facsimile: (205)458-5100
rrutherford@burr.com
bshirley@burr.com

Sarah R. Craig
BURR & FORMAN LLP
One Tampa City Center
Suite 3200
201 North Franklin Street
Tampa, Florida 33602
Telephone: (813)221-2626
Facsimile: (813)221-7335
scraig@burr.com

Attorneys for Defendant The Aliera Companies Inc.

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I. INTRODUCTION

This is an unusual case. Plaintiffs allege that they joined two separate healthcare sharing ministries ("HCSMs"), Unity Healthshare ("Unity") and Trinity Healthshare ("Trinity"). They sent sharing contributions to both HCSMs and sought sharing payments from them. Aliera, they claim, was involved in marketing, selling, and administering both HCSMs.

Plaintiffs launch a broad-scale attack on both Unity and Trinity's HCSMs. (*See* Doc. 1 at ¶¶ 77-83, 99, 164, 209, 240.) They assert that neither qualifies as a valid HCSM because neither complied with federal or Georgia law governing such programs. (*Id*. at ¶ 33.) As a result, applying some form of default rule, Plaintiffs allege that this qualification failure makes these two HCSMs illegal health insurance plans. (*Id*. at ¶ 33-34.)[1] They ask this Court to enjoin Aliera "and all others acting with it [presumably Unity and Trinity] from marketing, selling, and continuing to

[1] Both Trinity and Unity (n/k/a OneShare Health, Inc.) have consistently maintained in other proceedings that their programs are not insurance and that they are instead valid HCSMs. (*See e.g. George T. Kelly, III v. The Aliera Companies Inc., et al.*, No. 3:20-cv-05038 (W.D. Mo.), Doc. 40-1). The Court may take judicial notice of pleadings filed in these other proceedings. *See* Fed. R. Evid. 201; *Paez v. Sec'y, Fla. Dep't of Corr.*, 947 F.3d 649, 651 (11th Cir. 2020) ("Federal Rule of Evidence 201 permits a court to 'judicially notice a fact that is not subject to reasonable dispute because it ... can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned.'" (quoting Fed. R. Evid. 201(b)(2)); *Middlebrooks v. Experian Info. Sols., Inc.*, No. 1:18-cv-2720-SCJ, 2020 WL 1809566, at *5 (N.D. Ga. Mar. 3, 2020).

charge Plaintiffs and the Class for the pseudo-HCSM plans." (Doc. 1, Prayer for Relief.) Yet, they have chosen not to sue either entity that operated the healthcare sharing ministries they joined – Unity and Trinity.

Perhaps Plaintiffs believe their path to success will be easier if neither Unity nor Trinity appear in this case to defend the legal status of their HCSMs. But, more likely, the most reasonable explanation for this curious course of conduct is that Plaintiffs hope to avoid the alternative dispute resolution procedures contained in the Member Guides they received when they joined the Unity and Trinity HCSMs. But this strategy won't work because they expressly agreed to mediate and arbitrate all their "disputes" with Aliera as well. And, even if such an express agreement did not exist, Aliera could still invoke the mediation and arbitration procedures under well-settled principles of Georgia law.

The bottom line is that this case does not belong here. If Plaintiffs were serious about their claims against Aliera, they should have followed the alternative dispute resolution procedures they agreed to when they became Unity or Trinity members (mediation and then, if necessary, arbitration). Because they failed to do so, this case should either be dismissed outright or stayed while arbitration proceeds.

II. FACTUAL & PROCEDURAL BACKGROUND

A. The Nature of Unity and Trinity's HCSM and Aliera's Role In Administering Them.

Unity and Trinity are non-profit healthcare sharing ministries ("HCSM") comprised of members who adhere to a faith-based statement of beliefs. (Mot., Ex. A, Ex. 1, p. 2; Ex. 5, p. 20.) Historically, HCSMs are not considered insurance, and instead function as faith-based alternatives to traditional insurance. They offer a framework for individuals to freely associate with others who share a set of faith principles and to direct their contributions to a pool, in which members may share in the payment of other members' medical expenses. (*Id.*; *see also* Doc. 1 at ¶ 54.) In a certain sense, the HCSM structure is a formalized, special-purpose version of "passing the plate," which many churches have long endorsed as a way to help others with medical needs.

The HCSM structure differs from traditional insurance in several respects. The chief difference, as both Unity and Trinity explained to their members in the Member Guides, is that neither Unity nor Trinity ever assumes any contractual obligation (and takes no responsibility) to pay for any member's medical expenses from its own funds. (Mot., Ex. A at ¶¶ 8, 9, 13, 14, 19, 20, 26, 27.)[2] Nor is there

[2] *See Altura Healthshare, Inc. v. Deal*, 299 P.3d 197, 201 (Idaho 2013); *Barberton Rescue Missions, Inc. v. Ins. Div. of the Iowa Dep't of Commerce*, 586 N.W. 2d 352, 356 (Iowa 1998) (both cases holding that "insurance" was not involved because the entity involved assumed no risk of paying members' claims).

any guarantee that any specific member's requests for sharing will be paid out of other members' healthsharing contributions. (*Id.*) Trinity and Unity, in essence, act merely as clearinghouses for their members to share each other's medical expenses. (*Id.*)

Aliera is not an HCSM and does not purport to be one. (Mot., Ex. A at ¶ 4.) It is a for-profit entity that contracted with Unity and then Trinity (through its subsidiaries) to market memberships in their HCSMs and to create processes to facilitate member-to-member sharing of medical expenses. (*Id.* at ¶¶ 4-5; Doc. 1 at ¶¶ 61, 73.) Aliera has created a system that is designed to afford members the ability to consent to their contributions being shared on a real-time, case-by-case basis with other members as their needs arise. But, as previously noted, all members are informed that their requests for sharing payments may not be met – there are no guarantees.

B. Plaintiffs' Experiences With The Unity and Trinity HCSMs.

Each of the Plaintiffs originally enrolled in Unity's HCSM in 2018. (Mot., Ex. A at ¶¶ 6, 17, 24.) Each received the Unity Member Guides, and each made sharing contributions to Aliera for the benefit of Unity's HCSM. (*Id.* at ¶¶ 7, 18, 25.)

Each Plaintiff eventually ended their memberships with Unity and enrolled in Trinity's HCSM in 2019. Each made monthly sharing contributions to Aliera for the benefit of Trinity's HCSM, and each received Trinity Member Guides. (Doc 1 at

¶¶ 12, 23, 25.) While a member of either Unity or Trinity's HCSMs, each Plaintiff submitted sharing requests to cover medical expenses, and each claims those requests were denied. Each disputes those denials. (Doc. 1 at ¶¶ 8-31.) None of the Plaintiffs are current members of either Unity or Trinity's HCSMs. (Mot., Ex. A at ¶¶ 20, 23, 24.)

C. The Unity And Trinity Healthcare Membership Guides.

As previously mentioned, Plaintiffs allege that they were at one time Unity or Trinity members. As members, Plaintiffs concede that they received Member Guides for plans offered by Unity and Trinity and sold by Aliera. (Doc. 1 at ¶¶ 93, 106.)[3] These Membership Guides imposed several obligations on the members' part, the most pertinent of which at this juncture is complying with the dispute resolution procedures found in those Guides. (Mot., Ex. A at ¶¶ 10, 15, 21, 28, 31.) Trinity Members, for example, agreed that "**any dispute** [they] have with or against Trinity Healthshare, **its associates**, or employees will be settled using the following steps of action, and only as a course of last resort." (*Id.*) (emphasis added); *see also* Doc. 1 at ¶ 107 -- recognizing existence of Member Guide's mediation and arbitration requirements.) These include, in basic terms:

- 1st Level Appeal (telephone call with Trinity representative)

[3] Plaintiffs refer to these Member Guides (either directly or indirectly) throughout the Complaint. (*See* Doc. 1 at ¶¶ 35, 80, 85, 93, 106-113, 224.)

- 2nd Level Appeal (review by Internal Resolution Committee)
- 3rd Level Appeal (review by three sharing members in good standing)
- Final Appeal (review by medical expense auditor and other personnel)
- Mediation
- Arbitration

(*See* Mot., Ex. A, Exs. 4, 5, 7, 11 & 12 for a full explanation of the specific requirements for each step in this dispute resolution process.)[4] None of the Plaintiffs allege that they followed each of these steps in the dispute resolution process. In fact, they did not. (*See* Mot., Ex. A at ¶¶ 11, 16, 22, 29, 34.)

III. ARGUMENT

A. This Case Should Be Dismissed Without Prejudice Because Plaintiffs Failed To Abide By Their Obligations To Mediate Their Disputes.

Plaintiffs never attempted to mediate their disputes with Aliera. Their Complaint fails to allege otherwise. This means that Plaintiffs' claims are due to be dismissed without prejudice for failure to comply with a condition precedent contained in their Unity and Trinity Member Guides.

It is a nearly universal rule that failure to mediate a dispute pursuant to an antecedent agreement to mediate warrants dismissal of litigation. *See World of Beer*

[4] The Unity Member Guides contained virtually identical dispute resolution procedures. (*See, e.g.*, Mot., Ex. A at ¶¶ 10, 21 & 28.)

Franchising, Inc. v. MWB Dev. I, LLC, 711 F. App'x 561, 570 (11th Cir. 2017) (affirming denial of preliminary injunction where movant failed to first submit claims to mediation); *Woods v. Holy Cross Hosp.*, 591 F.2d 1164 (5th Cir. 1979) (affirming district court's dismissal of complaint where medical malpractice plaintiff failed to participate in mediation before filing complaint)*; Houseboat Store, LLC v. Chris-Craft Corp.*, 692 S.E.2d 61, 65 (Ga. Ct. App. 2010) ("[T]he mediation provision is a condition precedent to either party's right to file a lawsuit arising out of the disputes between them."). Stated otherwise, courts will strictly adhere to the parties' agreed dispute resolution procedures, including when mediation is set forth as a condition precedent. *Kemiron Atl., Inc. v. Aguakem Int'l, Inc.*, 290 F.3d 1287, 1291 (11th Cir. 2002).[5]

Plaintiffs cannot reasonably allege that the mediation procedures set forth in the Member Guides have no possibility to resolve their claims. Certainly the

[5] Courts throughout the country have enforced similar pre-suit dispute resolution procedures requiring mediation. *See, e.g., Primov v. Serco, Inc.*, 817 S.E.2d 811, 817 (Va. 2018) (dismissing a case where plaintiff failed to comply with provision in a contract requiring mediation to occur before either party could proceed to court); *see also DeValk Lincoln Mercury, Inc. v. Ford Motor Co.*, 811 F.2d 326, 336 (7th Cir. 1987) (dealer's failure to follow contractual obligation to mediate before filing suit justified dismissal of his case); *Carter v. Firestone*, No. 4:05 cv-2042 ERW, 2006 WL 1153808, at *4 (E.D. Mo. 2006) (dismissal for failure to first mediate), *aff'd*, 242 F. App'x 375 (8th Cir. 2007); *MB Am., Inc. v. Alaska Pac. Leasing*, 367 P.3d 1286, 1288-91 (Nev. 2016) (prelitigation mediation provision in the parties' contract constituted an enforceable condition precedent to litigation and justified dismissal of the complaint.

Plaintiffs' assertions that they were improperly denied payment for their sharing contribution requests are grist for the dispute resolution mill – there is a multi-step process (including mediation) designed to resolve precisely those claims. The alternative claims can also be resolved through a consensual arrangement forged in mediation. Thus, Plaintiffs' claims should be dismissed without prejudice at the outset because they failed to abide by the mediation requirement.

B. Alternatively, This Matter Should Be Sent To Arbitration.

This Court is not an appropriate forum for the Plaintiffs to maintain their claims for another fundamental reason. Their agreements with Unity and Trinity contain a binding arbitration clauses. So, if the Court does not dismiss the Complaint due to the Plaintiffs' failure to mediate, it should compel Plaintiffs to submit all their claims to arbitration. The arbitrator can then decide whether the Plaintiffs' claims can proceed before a mediation occurs. *See BG Grp., PLC v. Republic of Argentina*, 572 U.S. 25, 35 (2014) (arbitrators usually decide whether pre-arbitration procedural requirements have been followed).

Some background is needed to understand why arbitration should be compelled here. For centuries, there was a widespread judicial (and legislative) antipathy to arbitration agreements. *Hall Street Assoc., L.L.C. v. Mattel, Inc.*, 552 U.S. 576, 581 (2008). A number of centuries ago, the English courts, because of their "jealousy … for their own jurisdiction, refused to enforce specific agreements

to arbitrate upon the ground that the courts were thereby ousted from their jurisdiction.'" *Dean Witter Reynolds, Inc. v. Byrd*, 470 U.S. 213, 220 n.6 (1985) (quoting H.R. Rep. No. 96, 68th Cong., 1st Sess., 1-2 (1924)). "This jealousy survived for so long a period that the principle became firmly embedded in the English common law and was adopted with it by the American courts." *Id.*

When Congress passed the Federal Arbitration Act ("FAA") in 1925, "it was 'motivated, first and foremost, by a desire' to change this anti-arbitration rule," *Allied Bruce Terminix Cos. v. Dobson*, 513 U.S. 265, 270-71 (1995) (quoting *Byrd*, 470 U.S. at 220), and "to overrule the judiciary's longstanding refusal to enforce agreements to arbitrate." *Byrd*, 470 U.S. at 219-20. Congress therefore enacted the FAA in order to place arbitration agreements '"upon the same footing as other contracts, where [they] belong[].'" *Id.* at 219 (quoting H.R. Rep. No. 96, 68th Cong., 1st Sess., 1 (1924)).

The FAA accomplishes these purposes by establishing that a written arbitration provision contained in a "contract evidencing a transaction involving commerce … shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract." 9 U.S.C. § 2 (emphasis added). The Act mandates that "the court shall make an order directing the parties to proceed to arbitration in accordance with the terms of the agreement," upon application of one of the parties, if there has been a "failure, neglect, or refusal

of another to arbitrate under a written agreement for arbitration." 9 U.S.C. § 4 (emphasis added). The Act also provides that a court "shall" stay its proceedings if it is satisfied that an issue before it is arbitrable under the parties' agreement "until such arbitration has been had in accordance with the terms of the agreement." 9 U.S.C. § 3 (emphasis added). To abide by these Congressional mandates, courts must "rigorously enforce agreements to arbitrate." *Shearson/American Express, Inc. v. McMahon*, 482 U.S. 220, 226 (1987) (quoting *Byrd*, 470 U.S. at 221).

The FAA accomplishes much more than merely creating a mechanism to enforce an arbitration agreement: it establishes "a liberal federal policy favoring arbitration agreements" as a preferred method of dispute resolution. *Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 24 (1983). This federal policy favoring arbitration is so strong that it preempts any state law "to the extent that [the state law] stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Volt Info. Scis., Inc. v. Bd. of Trs. of Leland Stanford Junior Univ.*, 489 U.S. 468, 477 (1989) (citation omitted).

There are some limits to enforcement of an arbitration agreement. Section 2 of the FAA states that such an agreement is enforceable "save upon such grounds as exist at law or in equity for the revocation of any contract." 9 U.S.C. § 2. But this "saving clause" does not allow for "defenses that apply only to arbitration or that derive their meaning from the fact that an agreement to arbitrate is at issue." *AT&T*

Mobility LLC v. Concepcion, 563 U.S. 333, 339 (2011). A state law or rule forbidding or limiting arbitration can find no help from the "saving clause" of section 2 of the FAA if it "prohibits outright the arbitration of a particular type of claim." *Id.* at 341. Nor does a state law or rule find refuge in the "saving clause" if it would "interfere[ ] with fundamental attributes of arbitration." *Lamps Plus, Inc. v. Varela*, 139 S. Ct. 1407, 1418 (2019) (citing *Concepcion*, 563 U.S. at 344).

Under the FAA, an arbitration agreement must be enforced where: (1) there is a written agreement to arbitrate claims, (2) the transaction has a nexus to interstate commerce, and (3) the arbitration clause encompasses the claims. 9 U.S.C. § 2. Once again, each of these inquiries must be undertaken against the background of a "liberal federal policy favoring arbitration agreements." *Moses H. Cone Mem'l Hosp,* 460 U.S. at 24; *see also Marmet Health Care Ctr., Inc. v. Brown*, 565 U.S. 530, 532-33 (2012). Given the strong federal policy favoring arbitration, "the party resisting arbitration bears the burden of proving that the claims at issue are unsuitable for arbitration." *Green Tree Fin. Corp.-Ala. v. Randolph*, 531 U.S. 79, 91 (2000).

1. The Agreements to Arbitrate Are Valid and in Writing.

State contract law controls the question of whether a valid agreement to arbitrate has been formed. *First Options of Chicago, Inc. v. Kaplan*, 514 U.S. 938, 944 (1995). Under Georgia law, a written agreement to submit an existing controversy or a controversy arising thereafter to arbitration is valid and enforceable.

Galindo v. Lanier Worldwide, 526 S.E.2d 141, 145-46 (Ga. Ct. App. 1999). And, taking it one step further, under Georgia law, any doubts about whether an agreement to arbitrate applies to a particular dispute are to be resolved in favor of sending the parties to arbitration. *SunTrust Bank v. Lilliston*, 809 S.E.2d 819, 821 (Ga. 2018).

Both the Unity and Trinity Membership Guides state, in writing, that "**any dispute**" that each Plaintiff may have with Unity or Trinity **"or its associates"** shall be submitted to arbitration conducted in accordance with certain arbitration association rules. (*See* Mot., Ex. A at ¶¶ 10, 15, 21, 28, 33.) When they joined their respective HCSMs, Plaintiffs affirmed that any expenses they submitted for sharing would be subject to the Unity or Trinity sharing guidelines contained in the Membership Guides. (*See, e.g.*, Mot, Ex. A, Ex. 4, p. 5; Ex. 5, p. 3.) Plaintiffs further manifested their assent to the terms governing membership in the Unity and Trinity HCSMs by sending monthly membership contributions to Aliera for the benefit of Unity first, and then Trinity. (Mot., Ex. A at ¶¶ 7, 12, 18, 23, 25.) Both Membership Guides, therefore, contain a valid, written agreement by Plaintiffs to arbitrate "any dispute" between them, and either Unity or Trinity **"or its associates**."

2. Interstate Commerce Is Present.

Section 2 of the FAA requires that the parties' transaction involved "commerce." 9 U.S.C. § 2. The term "involving commerce" has been interpreted as the functional equivalent of the more familiar term "affecting commerce" and

"encompasses a wider range of transactions than those actually 'in commerce' – that is, 'within the flow of interstate commerce.'" *Citizens Bank v. Alafabco, Inc.*, 539 U.S. 52, 56 (2003) (citing *Allied-Bruce Terminix*, 513 U.S. at 273)). What that means is that "Congress' Commerce Clause power 'may be exercised in individual cases without showing any specific effect upon interstate commerce' if in the aggregate the economic activity in question would represent 'a general practice . . . subject to federal court.'" *Citizens Bank*, 539 U.S. at 56-57 (citing *Mandeville Island Farms, Inc. v. Am. Crystal Sugar Co.*, 334 U.S. 219, 236 (1948)). The FAA extends to the full reach of the Commerce Clause. *See Allied-Bruce Terminix*, 513 U.S. at 270; *Perry v. Thomas*, 482 U.S. 483, 490 (1987).

The "commerce" requirement is easily met here. Plaintiffs LeCann and Selimo live in New York and New Jersey, respectively. (Doc. 1 at ¶¶ 8, 18.) They sent monthly sharing payments from their home states to Aliera in Georgia for the benefit of the Unity and Trinity HCSMs. (*Id*. at ¶¶ 10, 13, 20, 22; Mot., Ex. A at ¶¶ 35-36.) And, while Plaintiff Funduk is a Georgia resident, her sharing contributions were part of a larger group of contributions made by other members in the Unity and Trinity HCSMs. (Mot., Ex. A at ¶¶ 35-36.) On behalf of Unity and Trinity, Aliera received sharing contributions from members across the country, interacted with members and their local medical care providers, and processed payments to providers from the members' contributions throughout the country. (*Id*.)

3. The Arbitration Agreement Encompasses All of Plaintiffs' Claims.

The arbitration agreement here unquestionably encompasses each claim in this case. When determining the scope of an arbitration provision, "due regard must be given to the federal policy favoring arbitration, and ambiguities as to the scope of the arbitration clause itself resolved in favor of arbitration." *Volt Info.*, 489 U.S. at 476. The presumption of arbitrability, created by the mere existence of an arbitration clause, may be rebutted only if "it may be said with positive assurance that the arbitration clause is not susceptible of an interpretation that covers the asserted dispute. Doubts should be resolved in favor of coverage." *AT&T Techs., Inc. v. Commc'ns Workers of Am.*, 475 U.S. 643, 650 (1986) (citation omitted). Where, as here, the arbitration clause is a broad one (covering "all disputes"), the presumption in favor of arbitrability applies with even greater force. *Id.*

The present dispute between Plaintiffs and Aliera is clearly within the scope of the Unity and Trinity Membership Guides' broad arbitration provisions. Both of the Membership Guides refer to arbitration of "**any dispute.**" (Mot., Ex. A at ¶¶ 10, 15, 21, 28 & 33.) The "disputes" contemplated by the Unity and Trinity Membership Guides specifically include, by example, any "determination" made by Unity, Trinity, or their "associates" with which Plaintiffs disagree. (*Id.*) The Plaintiffs allege that Unity, Trinity, and Aliera improperly refused to pay their medical expenses. (*See generally* Doc. 1.) A determination as to covered medical expenses

is exactly the sort of dispute contemplated in the alternative dispute resolution procedures contained in the Membership Guides. Plaintiffs' disputes should be arbitrated in accordance with the express written agreement of the parties.

4. All Possible Challenges To The Enforceability Of The Arbitration Provision Must Also Be Resolved By The Arbitrator.

Not only are each of Plaintiffs' substantive claims subject to arbitration, but any potential defenses Plaintiffs may have to the arbitrability of their claims must also be submitted to arbitral resolution. Binding Supreme Court decisions foreclose any contrary arguments.

First, Plaintiffs certainly cannot challenge the validity of the arbitration provisions by asserting that the Unity and Trinity Member Guides containing them are unenforceable because those arrangements are illegal contracts. The Supreme Court has directly foreclosed such an approach in *Buckeye Check Cashing, Inc. v. Cardegna*, 546 U.S. 440 (2006). In that case, the borrowers sought to avoid arbitration by asserting that the loan agreements containing them were illegal contracts because they violated Florida's usury laws. The Supreme Court flatly rejected this argument, holding that where a party advances a challenge to "the validity of the contract as a whole, and not specifically to the arbitration clause," the challenge "must go to the arbitrator." *Id.* at 449. *Accord Preston v. Ferrer*, 552 U.S. 346, 353-54 (2008) (holding that an arbitrator had to decide a contractual dispute

even though one of the parties alleged that the contract containing the arbitration provision was illegal under California law); *Jenkins v. First Am. Cash Advance of Ga., LLC*, 400 F.3d 868, 880-82 (11th Cir. 2005); *John B. Goodman Ltd. P'ship v. THF Constr., Inc.*, 321 F.3d 1094, 1095 (11th Cir. 2003); *Schklar v. Evans*, No. 1:15-cv-2265-AT, 2015 WL 9913859, at *3-4 (N.D. Ga. Dec. 29, 2015).

Second, the parties in this case have delegated all issues as to the validity or enforceability of the arbitration agreement to the arbitrator. They accomplished this in the Unity Member Guide by incorporating the rules of the Institute for Christian Conciliation, and in the Trinity Member Guide by incorporating the rules of the American Arbitration Association. (Mot., Ex. A at ¶¶ 10, 15, 21, 28 & 33.) Under each set of arbitration rules (ICC Rule 34(B); AAA Commercial Rule 7(a); AAA Consumer Rule 14(a), the arbitrator is given the power to rule on his or her own jurisdiction, including any challenges to the existence, scope, or validity of the arbitration agreement. (*See adr.org/commercial; adr.org/consumer; https://peacemaker.training/guidelinesforchristianconciliation/.*)

Both the Supreme Court and the Eleventh Circuit have concluded that these types of clauses delegating all gateway issues to the arbitrator, whether expressly stated in the agreement or incorporated by reference in arbitral body rules, are enforceable and provide clear and unmistakable evidence that the parties agreed to arbitrate arbitrability. *See Rent-A-Center W., Inc. v. Jackson*, 561 U.S. 63, 72-73

(2010); *U.S. Nutraceuticals, LLC v. Cyanotech Corp.*, 769 F.3d 1308, 1311 (11th Cir. 2014); *Terminix Int'l Co. v. Palmer Ranch Ltd. P'ship*, 432 F.3d 1327, 1332 (11th Cir. 2005).[6] Most courts, moreover, have concluded that these "rule-incorporation" delegations of arbitrability also assign to the arbitrator the question of whether a non-signatory can invoke an arbitration provision in a suit brought by a signatory. *See Blanton v. Domino's Pizza Franchising LLC*, 962 F.3d 842 (6th Cir. 2020) (collecting cases). Thus, any challenge that Plaintiffs could possibly raise to defeat or avoid the arbitration provisions must be decided in the first instance by the arbitrator, not the Court.

Finally, the Plaintiffs cannot successfully mount a challenge to an arbitration provision that will require a court to decide the ultimate merits issues in the case (*e.g.*, whether Unity or Trinity's plans were actually "insurance"). As a general rule, the arbitrator decides all merits-related disputes, *First Options*, 514 U.S. at 944, unless such a dispute is specifically excluded in the arbitration agreement itself. *See Jpay, Inc. v. Kobel*, 904 F.3d 923, 929 (11th Cir. 2018). And, the Supreme Court

[6] This Court has reached the same conclusion. *See Nat'l Freight, Inc. v. Consol. Containers Co.*, 166 F. Supp. 3d 1320, 1324 (N.D. Ga. 2015). This Court has also concluded that where there is a delegation clause -- either an express clause or one found in an incorporated rule -- it stands apart from the rest of the arbitration agreement and has to be challenged directly to avoid the result that an arbitrator decides all arbitrability issues. *See Githieya v. Global Tel Link Corp.*, No. 1:15-cv-0986-AT, 2016 WL 304534, at *4 (N.D. Ga. Jan. 25, 2016).

recently made clear that even if the Court believes that a claim of arbitrability is wholly groundless, "a court may not 'rule on the potential merits of the underlying' claim that is assigned by contract to an arbitrator." *Henry Schein, Inc. v. Archer & White Sales, Inc.*, 139 S. Ct. 524, 529 (2019) (quoting *AT&T Techs.*, 475 U.S. at 649-50 (a court has "no business weighing the merits of the grievance" – that is for the arbitrator)); *S. Jersey Sanitation Co. v. Applied Underwriters Captive Risk Assurance Co.*, 840 F.3d 138, 146 (3d Cir. 2016) (an arbitrator, not the court, had to decide the ultimate merits issue of whether the transactions at issue constituted insurance). A court, moreover, should also not prejudge how an arbitrator might resolve uncertainties around key merits issues in order to wrest that decision from the arbitrator. *See PacifiCare Health Sys., Inc. v. Book*, 538 U.S. 401, 406-07 (2003).

C. Aliera May Enforce the Alternative Dispute Resolution Provisions.

1. Those Provisions Expressly Encompass Claims Against Aliera.

The alternative dispute resolution provisions, requiring mediation followed by arbitration, cover not only any disputes the Plaintiffs may have against Unity or Trinity, but also any disputes they have with Aliera.[7] As previously noted, both Unity and Trinity's member benefit guides provide that all disputes that a member

[7] Moreover, any issue whether the arbitration agreement expressly incorporates Aliera is a question the parties have likewise delegated to the arbitrator.

may have with an "**associate**" of Unity or Trinity must also be submitted to mediation in the first instance, followed by arbitration.

The plain meaning of the term "associate" encompasses Aliera under the circumstances of this case. One commonly-used dictionary defines the noun "associate" as "one associated with another," and lists "business associates" as an example. *See* Associate, *Merriam-Webster Dictionary*, available at https://www.merriam-wbster.com/dictionary/associate. *See also Webster's Third New International Dictionary* 132 (1992) ("associate" means a person "closely connected, joined, or united with another"); A. Scalia & B. Garner, *Reading Law: The Interpretation of Legal Texts* 69 (2012) (terms should be given their "ordinary, everyday meanings – unless the context indicates that they bear a technical sense").

Clearly, Plaintiffs perceive Aliera as an "associate" of both Unity and Trinity. The entire thrust of the Complaint is that Aliera (i) either created or worked to form both Unity and Trinity's HCSMs; (ii) marketed, sold, and administered both of the HCSMs involved here; and (iii) worked hand-in-hand with Unity and Trinity to accomplish what Plaintiffs allege is a wide-ranging course of illegal conduct. (*See* Doc. 1 at ¶¶ 1-3, 33, 35, 58-61, 65-67.) Thus, there can be no legitimate dispute that Aliera, under Plaintiffs' own allegations, qualifies as an "associate" of both Unity and Trinity.

2. Aliera Can Invoke The Arbitration Provision Under Generally-Applicable Principles Of Equitable Estoppel And Agency.

Even assuming that Plaintiffs' agreements to arbitrate their disputes with "associates" of Unity and Trinity do not expressly incorporate Aliera, Georgia principles of equitable estoppel permit Aliera to invoke the arbitration provisions. As this Court explained in *National Freight*, Georgia courts apply equitable estoppel in two situations:

> First, cases in which the "signatory to a written agreement … must rely on the terms of the written agreement in asserting its claims against the nonsignatory." Second, … "when the signatory to the contract containing the arbitration clause raises allegations of substantially interdependent and concerted misconduct by both the nonsignatory and one of more signatories to the contract."

166 F. Supp. 3d at 1328 (citations omitted). *Accord Order Homes, LLC v. Iverson*, 685 S.E.2d 304, 310 (Ga. Ct. App. 2009); *Price v. Ernst & Young, LLP*, 617 S.E.2d 156, 159-60 (Ga. Ct. App. 2005); *LaSonde v. CitiFinancial Mortg. Co.*, 614 S.E.2d 224, 226 (Ga. Ct. App. 2005); *Lankford v. Orkin Exterminating Co.*, 597 S.E.2d 470, 474 (Ga. Ct. App. 2005); *AutoNation Fin. Servs. Corp. v. Arain*, 592 S.E.2d 96, 100-01 (Ga. Ct. App. 2003) (all five cases applying equitable estoppel principles to allow non-signatory to arbitrate).

Both situations are present here. First, a portion of Plaintiffs' claims rest upon (or at least are related to) the written terms of the Unity and Trinity Member Guides. For example, the Member Guides detail the guidelines for sending sharing

contributions, the types of medical expenses that may qualify for sharing payments, how to submit sharing requests, and what to do if a member disputes a decision about sharing. (Mot., Ex. A, Exs. 4, 5, 7, 11 & 12.) Plaintiffs assert that they submitted sharing requests for medical expenses that were "covered expenses" under the Member guidelines, that Aliera should be required to honor those sharing requests, and that Aliera is legally responsible under breach of contract theories to pay the Plaintiffs' medical expenses. (Doc. 1 at ¶¶ 7-31, 112-113, 172-75.) Because these allegations and theories are dependent upon, or at least arise in part from, the contents of the Unity and Trinity Member Guides, Plaintiffs cannot seek to use those Guides as bases for their claims and then disavow the dispute resolution procedures contained therein. *See Blinco v. Green Tree Servicing LLC*, 400 F.3d 1308, 1312 (11th Cir. 2005); *A.L. Williams & Assocs., Inc. v. McMahon*, 697 F. Supp. 488, 494 (N.D. Ga. 1988); *LaSonde*, 614 S.E.2d at 226 (all three cases allowing a nonsignatory to invoke an arbitration clause by applying equitable estoppel where similar allegations were made).

Likewise, if anything can be said about Plaintiffs' complaint, it is that there are numerous allegations of interdependent and concerted misconduct by Unity, Trinity, and Aliera. For example, Plaintiffs assert that Aliera "acted in concert with third parties, including Unity … and Trinity … to issue its putative HCSM plans in an attempt to give those plans an appearance of legality," even though those two

companies, "as operated and created by Aliera, did not (and do not) meet the qualifications of an HCSM under federal or Georgia law." (Doc. 1 at ¶ 33.) Plaintiffs further allege that Aliera, Unity, and Trinity "have combined their respective property, experience, labor, and know-how to form a joint undertaking" and have "portrayed themselves and operated as a single enterprise, such that a reasonable consumer would not appreciate any meaningful difference between Aliera and these companies (such as Trinity)." (*Id.* at ¶ 35.) Plaintiffs go so far as to allege that Trinity is "a mere shell entity operated, administered, and directed by Aliera solely to serve Aliera's purposes," (*id.* at ¶ 67), and that Aliera "squandered, stole, and diverted" money to "Trinity" and others, (*id.* at ¶ 197). Indeed, the Complaint is replete with allegations that Aliera, Unity, and Trinity all engaged in joint actions that supposedly injured the Plaintiffs. (*See generally* Doc. 1); *see Becker v. Davis*, 491 F.3d 1292, 1304 (11th Cir. 2007) (recognizing that allegations of collusive or conspiratorial conduct between signatory and nonsignatory defendants were sufficient to warrant application of equitable estoppel principles and allow the nonsignatory to compel arbitration); *MS Dealer Serv. Corp. v. Franklin*, 177 F.3d 942, 947 (11th Cir. 1999) (equitable estoppel doctrine applied to allow nonsignatory defendant to arbitrate under an arbitration clause covering "all disputes … between the parties hereto").

Plaintiffs can't avoid these principles and their contractual agreements to arbitrate by exploiting their decision not to sue Unity or Trinity. Aliera can invoke the arbitration clause even if the two signatory parties (Unity and Trinity) are not present. *See AutoNation Fin. Servs.*, 592 S.E.2d at 101-02 (nonsignatory could still enforce arbitration provision even after the signatory defendant had been dismissed from the case). *Accord MS Dealer Serv. Corp.*, 177 F.3d at 946-47 (a nonsignatory could enforce an arbitration provision even though its alleged conspirator, who was a signatory to the arbitration agreement, was not a party to the action); *see also Grigson v. Creative Artists Agency, L.L.C.*, 210 F.3d 524 (5th Cir. 2000); *Roberson v. Money Tree of Ala., Inc.*, 954 F. Supp. 1519, 1529 (M.D. Ala. 1997) (both cases allowing nonsignatories to enforce an arbitration agreement even though the signatory entity was never (or no longer) a party to the lawsuit).

In sum, as this Court concluded in *National Freight*, "'the ends of justice are more nearly met' by estopping [Plaintiffs] from avoiding arbitration of [their] claims against [Aliera]." 166 F. Supp. 3d at 1329 (citation omitted). Their claims, all of them, belong in arbitration.[8]

[8] Additionally, Plaintiffs clearly assert Aliera was acting as an agent for Unity and then Trinity in the offer, sale, and administration of those entities' HCSMs. (Doc. 1 at ¶¶ 33, 61, 69, 73-76.) Under Georgia law, a nonsignatory *agent* of a signatory may enforce an arbitration agreement. *Comvest, L.L.C. v. Corp. Secs. Grp., Inc.*, 507 S.E.2d 21, 25 (Ga. Ct. App. 1998) ("[A]gents, employees, and representatives [of signatory] are also covered under the terms of [arbitration]

IV. CONCLUSION

Plaintiffs' memberships in the Unity HCSM, and subsequently the Trinity HCSM, were subject to alternative dispute resolution processes set forth in the respective Membership Guides. Aliera is covered by, or can legally invoke, those provisions. These provisions constitute valid, enforceable obligations for Plaintiffs to follow prior to initiating litigation. Plaintiffs failed to do so. As a result, Aliera respectfully moves this Court to either (1) dismiss this case without prejudice for the Plaintiffs' failure to pursue mediation first, or in the alternative (2) compel Plaintiffs to bring their claims in arbitration and stay all proceedings pending the conclusion of the arbitral process pursuant to 9 U.S.C. § 3.

Respectfully submitted on July 16, 2020.

/s/ Sarah R. Craig
Sarah R. Craig
Georgia Bar No. 463578
Primary Email: scraig@burr.com
BURR & FORMAN, LLP
One Tampa City Center
201 North Franklin Street, Ste. 3200
Tampa, Florida 33602
Telephone: (813) 367-5766
Facsimile: (813) 221-7335

Counsel for Defendant,
The Aliera Companies Inc.

agreements." (citation omitted)); *see also MS Dealer Serv. Corp.*, 177 F.3d at 947 (same).

CERTIFICATE OF SERVICE

A copy of the foregoing **DEFENDANT ALIERA'S MEMORANDUM OF LAW IN SUPPORT OF ITS MOTION TO DISMISS, OR ALTERNATIVELY, TO COMPEL ARBITRATION AND TO STAY PROCEEDINGS** has been filed this 16th day of July, 2020 via the Court's CM/ECF system, which will send notification of such filing to all parties of record as noted below.

David F. Walbert
Jennifer Kathleen Coalson
Parks Chesin & Walbert, P.C. – Atlanta
Suite 2600
75 Fourteenth Street, N.E.
Atlanta, GA 30309
dwalbert@pcwlawfirm.com
jcoalson@pcwlawfirm.com

Paul Sweeny
Stephen J. Fearon, Jr.
Squitieri & Fearson, LLP – New York
32 East 57th Street
New York, NY 10022
paul@sfclasslaw.com
stephen@sfclasslaw.com

/s/ Sarah R. Craig
OF COUNSEL