

2018 MEMBER GUIDE



ALIERACARE™

BRONZE | SILVER | GOLD

INDIVIDUAL & FAMILY



AlierACare Plans are NOT Insurance.

CONTENTS

- Member Guide 4**
 - Welcome 4
 - Member Portal 4
 - Contact Information 4
 - Plan Services & Membership at a Glance 6
 - Getting Started 8

- Part I:**
- How to Use Your Membership 11**
 - Telemedicine 11
 - Preventive Care 12
 - Urgent Care 13
 - Primary Care 14
 - Specialty Care 15
 - Hospitalization 15

- Part II:**
- How Your Healthcare Cost-Sharing Ministry (HCSM) Works 16**
 - Terminology 17
 - Plan Change Information 19
 - Statement of Beliefs 20
 - Definition of Terms 21
 - Contributors' Instructions and Conditions 22

- Part III:**
- Your Summary of Cost-Sharing, Eligible Needs, & Limits 23**
 - Limits of Sharing 27
 - Medical Expenses Not Generally Shared By HCSM 29
 - Pre-Authorization Required 31
 - Dispute Resolution and Appeal 32
 - Appendix A: Plan Details Bronze Level 34
 - Appendix A: Plan Details Silver Level 35
 - Appendix A: Plan Details Gold Level 36
 - Appendix A: Plan Details Bronze 37
 - Appendix A: Plan Details Silver 38
 - Appendix A: Plan Details Gold 39
 - Appendix B: Terms, Conditions, & Special Considerations 40
 - Abbreviations 41
 - Appendix C: Legal Notices 42

MEMBER GUIDE

WELCOME

Welcome to Alieria 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: 990 Hammond Drive, Suite 700
Atlanta, GA 30328

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

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.

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 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.

PLAN SERVICES & MEMBERSHIP AT A GLANCE

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 AleraCare 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 AleraCare 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

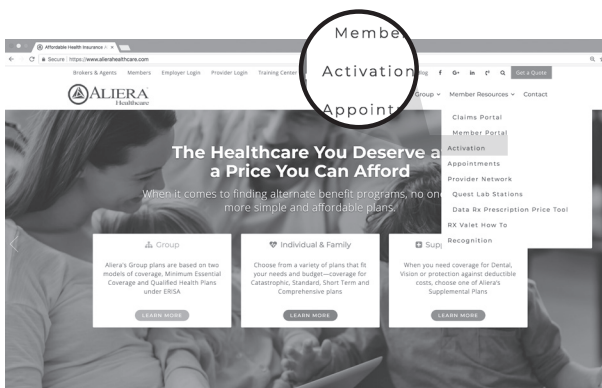
What does it mean?

Many of the terms used in describing health cost-sharing may be unfamiliar to those new to the programs and plans provided by Alera 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 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.

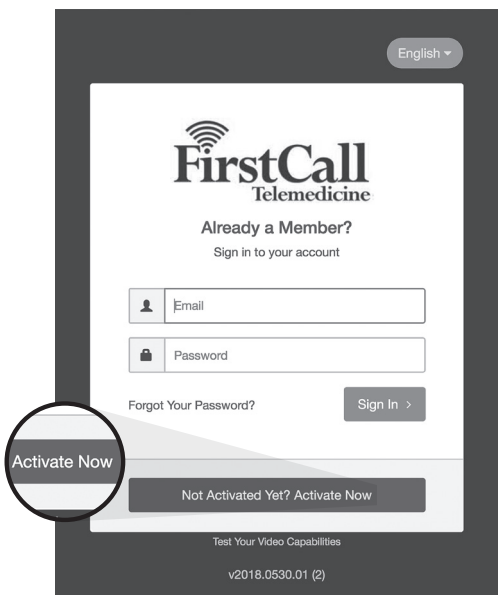


2. Set Up Your Telemedicine Account

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.

GETTING STARTED



- 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 Alera Healthcare ID card
2. For your Group ID type in Alera
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.

GETTING STARTED

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 Alera 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.

How to Use Your Membership

The Telemedicine Program

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 Alier'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.

- ▶ AlierCare 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 or hospital emergency room to receive urgent medical attention.
3. AlierCare products are not health insurance plans and Alier nor Trinity 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. Alier 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.

- ▶ AlierCare 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

AlierCare 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 Alier 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.

How Your Healthcare Cost-Sharing Ministry (HCSM) Works

Membership Overview

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.

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 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.

MEMBERSHIP QUALIFICATIONS

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. AleraCare 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

DEFINITION OF TERMS

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.

Your Summary of Cost-Sharing, Eligible Needs, & Limits

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 (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. **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.

YOUR SUMMARY OF COST-SHARING, ELIGIBLE NEEDS, & LIMITS

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.
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 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.
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.

YOUR SUMMARY OF COST-SHARING, ELIGIBLE NEEDS, & LIMITS

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.
26. **Prescription Drugs.** The AlierCare plan includes a service by RX Valet, which includes discounts for prescription drugs. See Appendix for details.
27. **Preventive.** Most programs from either Trinity or AlierCare 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.
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 AlierCare 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.

YOUR SUMMARY OF COST-SHARING, ELIGIBLE NEEDS, & LIMITS

37. **Speech Therapy.** Up to six (6) visits per membership year. Only applicable after a stroke.
38. **Surgical Offerings.** Non-life-threatening surgical offerings 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 AlierCare programs offered by Trinity HealthShare and Alier 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 (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. 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

LIMITS OF SHARING (MAXIMUM PAYABLE)

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 Office Visit – PCP
25. Gender Dysphoria Office Visit – Specialist
26. Gender Dysphoria
27. Genetic Testing
28. Group Therapy Services
29. Hemodialysis

MEDICAL EXPENSES NOT GENERALLY SHARED BY HCSM

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, ultralights, 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.

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. 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 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 Services¹ 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.	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 Services¹ 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	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 38

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 Services¹ 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 39

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 Trinity HealthShare mailing address, Attn. Trinity 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. 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

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 Trinity HealthShare mailing address, Attn. Trinity 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. 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

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 Trinity HealthShare mailing address, Attn. Trinity 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. 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: 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; Alera 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 Alera'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. Alera cannot guarantee that a provider will accept an Alera Plan if the Member fails to contact the Alera 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 Alera's network at any time without notice.
14. Not all geographical areas are serviced by Alera Healthcare. Should a Member visit an emergency room because urgent care facilities are unavailable in the Member's area, Alera 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. Alera 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 AleraCare plan. While Alera offers one of the largest PPO networks in the country, some providers may not participate.

Disclosures

1. Alera Healthcare, the Alera Healthcare logo, and other plan or service logos are trademarks of Alera Healthcare, Inc. and may not be used without written permission.
2. Alera and Trinity programs are NOT insurance. Alera 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. Alera’s Healthcare Plans offer services only to Members and dependents on your Plan.
4. Alera 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 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 Alera 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

APPENDIX C: LEGAL NOTICES

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

APPENDIX C: LEGAL NOTICES

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

APPENDIX C: LEGAL NOTICES

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

APPENDIX C: LEGAL NOTICES

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

APPENDIX C: LEGAL NOTICES

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

APPENDIX C: LEGAL NOTICES

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:

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990 Hammond Drive, Suite 700
Atlanta, GA 30328
Toll-Free 844-834-3456
www.alierahealthcare.com

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