

MEMBER GUIDE & SHARING NEEDS



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MEMBER GUIDE

WELCOME!

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

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

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

Member Portal

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

Contact Information

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

Phone: 844-834-3456

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

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

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

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

Disclaimer

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

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

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

PLAN SERVICES AND MEMBERSHIP AT A GLANCE

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



PREVENTIVE CARE

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

EPISODIC PRIMARY CARE

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

CHRONIC CARE

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

LABS & DIAGNOSTICS

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

TELEMEDICINE

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

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

PRESCRIPTION DRUG PROGRAM

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

URGENT CARE

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



MEMBERSHIP

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

HOSPITALIZATION

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

SURGERY

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

GETTING STARTED

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

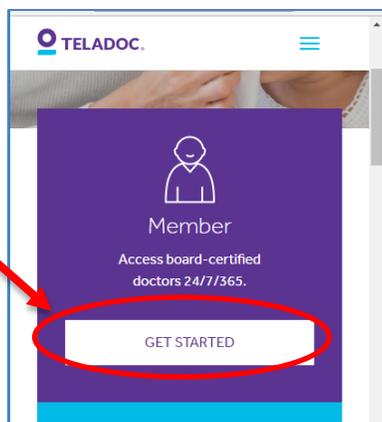
1. Activate Your Membership

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



2. Set Up Your Telemedicine Account

Follow the steps below to set up your telemedicine account. If you have not activated your Membership Card, or if your Membership fees are not paid up to date, you are not eligible to set up your telemedicine account.



Set up your account (Primary Member)

Visit www.teladoc.com, Click "Set up account." Follow the online instructions and provide the required information, including your medical history.

Set up minor dependents (17 years or younger)

Log in to your account and click "My Family" on the top menu. Follow the online instructions to provide the necessary information and complete your dependent's medical history.

Set up adult dependents (18 – 26 years)

Adult dependents must set up their own account. Visit the website and click "Set up account." Follow the online instructions to provide the required information and to complete your medical history.

3. Review Your Benefits

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

PART I

How to Use Your Membership

THE TELEMEDICINE PROGRAM

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

Benefits of the Telemedicine Program

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

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

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

CONCIERGE SERVICE & CARE COORDINATION

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

How to Use the Concierge Service

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

PREVENTIVE CARE

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

How to Use Preventive Care Services

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

LABS AND DIAGNOSTICS

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

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

How to Access MyQuest

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

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

URGENT CARE

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

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

How to Use the Urgent Care Service

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

If Urgent Care Services are Unavailable

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

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

PRIMARY CARE FOR SICK CARE

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

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

How to Use Primary Care Service for Sick Care

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

PRIMARY CARE FOR SICK CARE AND CHRONIC MAINTENANCE

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

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

How to Use Primary Care Service for Sick and Chronic Care

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

SPECIALTY CARE

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

HOSPITALIZATION

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

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

PPO NETWORK

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

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

Find a Network Healthcare Professional

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

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

PART II

How Your Healthcare Cost Sharing Ministry (HCSM) Works

MEMBERSHIP OVERVIEW

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

Guidelines Purpose and Use

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

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

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

Individuals Helping Individuals

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

MEMBERSHIP QUALIFICATIONS

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

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

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

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

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

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

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

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

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

Financial Participation. Monthly contributions are requested to be received by the 1st or 15th of each month depending on the member's effective date. If the monthly contribution is not received within 5 days of the due date, an administrative

fee will be assessed to track, receive, and post the monthly contribution. If the monthly contribution is not received by the end of the month, a membership will become inactive as of the last day of the month in which a monthly contribution was received.

Any member who has a membership that has become inactive will be able to reapply for membership under the terms outlined to them in writing by Unity HealthShareSM. Any member who submits a monthly contribution in such a manner as to have a membership become inactive three times will not be able to reapply for membership.

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

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

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

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

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

MONTHLY CONTRIBUTIONS

Monthly contributions are voluntary contributions or gifts that are non-refundable. As a non-insurance membership, neither Unity HealthShareSM nor the membership are liable for any part of an individual's medical need. All contributors are responsible for their own medical needs. Although monthly contributions are voluntary contributions or gifts, there are administrative costs associated with monitoring the receipt and disbursement of such contributions or gifts. Therefore, declined credit cards, returned ACH payments, or any contribution received after the 1st or 15th of each month will incur an administrative fee.

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

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

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

- a) has paid a monthly contribution and then cancels within 30 days of receiving medical attention, except within the last 90 days of the membership term;
- b) receives care within the first 60 days of the plan and cancels his membership within 30 days of receiving medical care;
- c) receives or requires surgery within the first 60 days of becoming a member except in the case of an accident.

EARLY VOLUNTARY TERMINATION

Members of the Unity HealthShare may terminate their membership at any time, with 30 days prior notice. Unity HealthShare plans are not a substitute for "short term medical plans". Medical expenses incurred during the term of the membership and followed by early voluntary termination within 90 days of incurring medical expenses, will be reviewed

and may not be eligible for cost sharing, where the early termination was not as a direct result of affordability issues with the health sharing program.

STATEMENT OF BELIEFS

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

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

DEFINITIONS OF TERMS

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

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

Application Date. The date Unity HealthShareSM receives a complete membership application.

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

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

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

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

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

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

Head of Household. Contributor participating by himself for herself; or the husband or father that participates in the membership; or the wife or mother if the husband does not participate in the membership.

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

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

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

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

Membership. All members of Unity HealthShareSM.

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

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

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

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

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

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

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

CONTRIBUTORS' INSTRUCTIONS AND CONDITIONS

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

Medical Expenses not generally shared by HCSM

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

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

1. Any medical care outside of a hospital, except in the case of a needed surgery due to an accident. Members may be able to use out-patient facilities based upon the nature of the medical need and at the sole discretion of Unity HealthShareSM. In addition, some plans of Unity HealthShareSM include primary, urgent, and specialty care. See the Appendix for your plan specifics.
2. Treatment or referrals received or obtained from any family member including, but not limited to, father, mother, aunt, uncle, grandparent, sibling, cousin, dependent, or any in-laws.
3. Pre-existing Conditions. Pre-existing conditions may vary based on plan option. Please see Appendix for specific plan details.
4. Illness or injuries caused by member negligence or for which the member has acted negligently in obtaining treatment. This could be documented by, but is not limited to, review of medical records or treatment plans by a licensed medical physician.
5. Procedures or treatments that are not recognized and approved by the American Medical Association (AMA) or that are illegal. Includes procedures not approved by the AMA for a given application, procedures still in clinical trials, procedures that are classified as experimental, or unproven interventions and therapies.
6. Lifestyles or activities engaged in after the application date that conflicts with the Statement of Beliefs (on the membership application).
7. Transportation (e.g., ambulance, etc.) for conditions that are not life-threatening, unless failure to immediately transport the member will seriously jeopardize the member's life; the additional expense for transportation to a facility that is not the nearest facility capable of providing medically necessary care; or charges in excess of \$10,000 for transportation by air.

8. Congenital birth defects.
9. Elective cosmetic surgery.
10. Breast implants (placement, replacement, or removal) and complications related to breast implants, including abnormal mammograms, unless related to an otherwise eligible need.
11. Elective abortion of a viable fetus/embryo, unless medically necessary to protect the life of the mother.
12. Infertility testing or treatment, as well as any birth control measures to prevent conception (i.e., the pill, IUDs, shots, etc.)
13. Sterilization or reversals (vasectomy and tubal ligation).
14. Hysterectomy without first obtaining two independent opinions (neither physician may be a partner or other affiliate of the other). Both doctors must examine the patient prior to surgery and both must find that a hysterectomy is medically necessary. The member is responsible to ensure that both physicians submit medical necessity to Unity HealthShareSM prior to surgery. Failure to follow these procedures will result in a finding of ineligibility for sharing by the membership.
15. Weight control and management including nutritional counseling for weight loss, weight gain, or health maintenance.
16. Hospital stays exceeding 60 days per medical need or additional charges for a private hospital room if a semi-private hospital room is available.
17. Any exams, physicals, or tests for which there are no specific medical symptoms, diagnosis in advance, or risk assessment testing.
18. Adult immunizations, HPV immunizations, and flu shots unless covered under an Alieria Healthcare part of the plan.
19. Chelation.
20. Physical therapy or occupational therapy that is not pre-authorized. Pre-authorized treatments are limited to a combined 6 visits in any calendar year.
21. Charges for emergency room visits and/or surgical removal for foreign objects placed in nose or ears by a child over five (5) years of age. Removal of foreign objects that can be done in an office setting will be reviewed under regular MSRAs or the Office Visit consult fee options.
22. Medication or procedures not requiring a prescription.
23. Purchase or rental of durable or reusable equipment or devices (e.g. oxygen, orthotics, hearing aids, prosthetics, and external braces), including associated supplies, diagnostic testing, or office visits.
24. Needs for active members submitted 9 months after the date of treatment. Needs for inactive members submitted 6 months after the date of treatment.
25. Dental services and procedures, including periodontics, orthodontics, temporomandibular joint disorder (TMJ), or orthognathic surgery. Includes hospital charges for dental work done under general anesthesiology. Dental work required during surgery from an accident shall be eligible for cost sharing when the dental work is required after an accident and while the member is still admitted to a hospital.
26. Optometry, vision services, glasses, contacts, supplies, vision therapy, refraction services, or office visits.
27. Psychiatric or psychological counseling, testing, treatment, medication, and hospitalization.
28. Mental or psychiatric health, learning disability, developmental delay, autism, behavior disorders, eating disorders, neuropsychological testing, alcohol/substance abuse counseling, attention deficit disorder, or hyperactivity.
29. Speech therapy (except for a deficit arising from stroke/trauma).
30. Circumcisions.
31. Self/inflicted or intentional injuries.
32. Acts of war.
33. Exposure to nuclear fuel, explosives, or waste.
34. Occupational injury resulting from an injury incurred while performing any activity for profit.
35. Consumption of a prescription drug not prescribed for the member or prescription drug prescribed for the member and taken in excess that causes an adverse reaction; illicit drug use by a member.
36. Illness or injury caused by the illegal activities of the member or the member's family, including misdemeanors and felonies, regardless of whether or not charges are filed.
37. Treatment, care, or services that is not medically necessary.
38. Emergency room services, unless treatment at an emergency room is the only legitimate option because of the severity of the condition and lack of availability of treatment at an alternative facility.
39. Sexually transmitted diseases.
40. Diseases, including HIV/AIDS, due to tattoos, body piercing, or life-style choices.
41. Allergy testing or immunotherapy treatment.
42. Second surgeries are eligible for sharing based on member's treatment plan and are subject to third party case management approval. Second surgeries on a previously eligible surgical need are not eligible unless the

member has followed through with the treatment plan laid out for him or her by their physician or complications occur within 15 days of eligible surgery.

43. Genetic testing and counseling.
44. Handling charges, conveyance fees, stat fees, shipping/handling fees, administration fees, missed appointment fees, telephone/email consultations, or additional charges for services supplied in an after-hours setting.
45. Drug testing unless required by membership.
46. Sexual dysfunction services.
47. Cancer sharing eligibility is different based on plan option chosen. Alieracare plans have a 12 month wait period for cancer. Sharing is available the 1st day of the 13 month of continuous membership. Any pre-existing or recurring cancer condition is not eligible for sharing. Cancer sharing will not be available for individuals who have cancer at the time of or five (5) years prior to application. If cancer existed outside of the 5-year time frame of a pre-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.
48. Adenoid removal surgery eligible for sharing only at 50% if member has had a prior surgery to remove tonsils and the adenoids were not removed at the same time.
49. Personal aircraft includes hang gliders, parasails, ultra-lights, hot air balloons, sky/diving, and any other aircraft not operated by a commercially licensed public carrier.
50. Extreme sports: Sports that voluntarily put an individual in a life-threatening situation. Sports such as but not limited to "free climb" rock climbing, parachuting, fighting, martial arts, racing, cliff diving, powerboat racing, air racing, motorcycle racing, extreme skiing, wingsuit, etc...

First 60 Days of Participation. *For sixty (60) days after Enrollment Date as a Sharing Member, medical expenses for any reason, other than accidents, illness or injury, are not eligible for sharing among members.*

PRE-AUTHORIZATION REQUIRED

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

Hospitalizations. Non-emergency prior to admission; emergency visits notification to Unity HealthShareSM within 48 hours.

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

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

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

Early detection provides the best chance for successful treatment and in the most cost effective manner. Effective January 1, 2017, the membership will require that all members aged 40 and older receive appropriate screening tests every other year – mammogram or thermography and pap smear with pelvic exams for women and PSA testing for men.

Failure to obtain biannual mammograms and gynecological tests listed above for women or PSA tests for men will render future needs for breast, cervical, endometrial, ovarian, or prostate cancer ineligible for sharing.

DISPUTE RESOLUTION AND APPEAL

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

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

- A. 1st Level Appeal.** Most differences of opinion can be resolved simply by calling Unity HealthShareSM who will try to resolve the matter within ten (10) working days in writing.
- B. 2nd Level Appeal.** If the sharing member is unsatisfied with the determination of the member services representative, then the sharing member may request a review by the Internal Resolution Committee, made up of three Unity HealthShareSM officials: the needs processing manager, the assistant director, and the executive director. The appeal must be in writing, stating the elements of the dispute and the relevant facts. Importantly, the appeal should address all of the following:
 1. What information does Unity HealthShareSM have that is either incomplete or incorrect?
 2. How do you believe Unity HealthShareSM has misinterpreted the information already on hand?
 3. Which provision in the Unity HealthShareSM Guidelines do you believe Unity HealthShareSM applied incorrectly?

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

- C. 3rd Level Appeal.** Should the matter remain unresolved, then the aggrieved party may ask that the dispute be submitted to three sharing members in good standing and randomly chosen by Unity HealthShareSM, who shall agree to review the matter and shall constitute an External Resolution Committee. Within thirty (30) days the External Resolution Committee shall render their opinion in writing.
- D. Final Appeal.** If the aggrieved sharing member disagrees with the conclusion of his/her fellow sharing members, then the aggrieved party may ask that the dispute be submitted to a medical expense auditor, who shall have the matter reviewed by a panel consisting of personnel who were not involved in the original determination and who shall render their opinion in writing within thirty (30) days.
- E. Mediation and Arbitration.** If the aggrieved sharing member disagrees with the conclusion of the Final Appeal Panel, then the matter shall be settled by mediation and, if necessary, legally binding arbitration in accordance with the Rules of Procedure for Christian Conciliation of the Institute for Christian Conciliation, a division of Peacemaker Ministries. Judgment upon an arbitration decision may be entered in any court otherwise having jurisdiction. Sharing members agree and understand that these methods shall be the sole remedy for any controversy or claim arising out of the Sharing Guidelines and expressly waive their right to file a lawsuit in any civil court against one another for such disputes, except to enforce an arbitration decision. Any such arbitration shall be held in Fredericksburg, Virginia, subject to the laws of the Commonwealth of Virginia. Unity HealthShareSM shall pay the fees of the arbitrator in full and all other expenses of the arbitration; provided, however, that each party shall pay for and bear the cost of its own transportation, accommodations, experts, evidence, and legal counsel, and provided further that the aggrieved sharing member shall reimburse the full cost of arbitration should the arbitrator determine in favor of Unity HealthShareSM and not the aggrieved sharing member. The aggrieved sharing member agrees to be legally bound by the arbitrator's decision. The Rules of Procedure for Christian Conciliation of the Institute for Christian Conciliation, a division of Peacemaker Ministries, will be the sole and exclusive procedure for resolving any dispute between individual members and Unity HealthShareSM when disputes cannot be otherwise settled.

PART III

Your Summary of Cost Sharing, Eligible Needs, & Limits

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

MEDICAL EXPENSES COVERED*

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

1. **Telemedicine.** Telemedicine is included in most programs offered by Unity HealthShareSM and Alieria Healthcare as your first line of defense. Your membership provides you and your family 24/7/365 access to a U.S. Board certified medical doctor.
2. **Preventive.** Most programs from either Unity HealthshareSM or Alieria provide everyone with the necessities of the 63 preventive care services as outlined by the United States Preventive Task force. (Excludes CarePlus Advantage.) Preventive care includes the PCP office visit and does not require a co-expense or consult fee.
3. **Labs & Diagnostics.** Your labs and diagnostics are covered when visiting a PCP or urgent care facility in network when your plan includes primary and urgent care. For labs at hospitals or other facilities, your MSRA will apply and you will be required to pay a co-expense of \$25.
4. **Urgent Care.** If your plan provides cost sharing for urgent care, you will have the added benefit of enjoying the ability to choose an urgent care facility in lieu of an emergency room. See the Appendix for any urgent care options and any limitations to plan.
5. **Primary Care.** Depending on your plan choice, primary care is at the core of preventing medical issues from escalating into a more catastrophic need. See Appendix for the specific plan details.
6. **Specialty Care.** Specialty care is included in most plans, but has limits defined by your specific plan design. Refer to the Appendix for specific details of MSRA and co-expense requirements.
7. **X-rays.** X-rays listed on your plan details in the Appendix are for imaging services at PCP or urgent care facilities only and requires a \$25 read fee per view at time of service. Your MSRA will apply to all other X-rays. MRI, CT Scans and other diagnostics must be paid with your MSRA before cost sharing is provided.
8. **Chronic Maintenance.** Chronic maintenance is eligible when a member has chosen a plan with chronic maintenance specifically included and a listing of the maximum number of allowable visits. See 'Appendix A' attached hereto.
9. **Emergency Room.** Emergency room services for stabilization or initiation of treatment of a medical emergency condition provided on an outpatient basis at a hospital, clinic, or urgent care facility, including when hospital admission occurs within twenty-three (23) hours of emergency room treatment.
10. **Hospitalization.** Hospital charges for inpatient or outpatient hospital treatment or surgery for a medically diagnosed condition.
11. **Surgical Benefits.** Non life threatening surgical benefits are not available for the first 60 days of membership for Premium plans and all other plans require 6 month wait period. **Please verify eligibility by calling Members Services before receiving any surgical services.**
12. **Prescription Drugs.** The AlieriaCare plan includes a service by RX Valet, which includes cost sharing for prescription drugs. See Appendix for details.
13. **Physical Therapy.** Up to six (6) visits per membership year for physical therapy by a licensed physical therapist.
14. **Ambulance.** Emergency land or air ambulance transportation to the nearest medical facility capable of providing the medically necessary care to avoid seriously jeopardizing the sharing member's life or health.
15. **Naturopathic and/or Alternative Treatments.** Does not included chiropractic services
16. **Prosthetics and their replacement, if medically necessary.** This is not an eligible sharing expense
17. **Medical Costs incurred outside the United States.** Charges for the care and treatment of a medically diagnosed condition when treatment outside the United States is financially beneficial or when traveling or residing outside the United States. Eligibility of such charges are subject to all other provisions of the Guidelines. Medical billing is requested to be submitted in English and converted to U.S. currency.
18. **Smoking Cessation.** Members with preventive coverage who have acknowledged they smoke and made an additional contribution are provided the opportunity to obtain free smoking cessation medication and counseling.

19. **Competitive Sports.** Plan holders who participate in organized and/or sanctioned competitive sports are eligible for \$5,000 (max) of sharing per incident at an emergency room, subject to the member-shared responsibility amount.
20. **Maternity.** Maternity medical expenses are only eligible for sharing in certain Plans. Please see the Appendix for your specific plan design. Medical expenses for maternity ending in a delivery by emergency cesarean section that is medically necessary are eligible for sharing up to \$8,000 subject to the applicable Member Shared Responsibility Amount. Medical expenses for a newborn arising from complications at the time of delivery, including, but not limited to, premature birth, are treated as a separate incident and limited to \$50,000 of eligible sharing, subject to the Member Shared Responsibility Amount. See the Appendix for specific sharing inclusions and limits for your plan choice.

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

LIMITS OF SHARING (MAXIMUM PAYABLE)

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

1. **Lifetime Limits.** \$1,000,000: the maximum amount shared for eligible needs over the course of an individual member's lifetime.
2. **Annual Limits.** The maximum amount shared for eligible needs per member per 12 month plan term.
3. **Per Term.** The limit for each term of a sharing plan. Generally, means annually except in the case of short-term cost sharing.
4. **Per Incident.** The occurrence of one particular sickness, illness, or accident.
5. **Cancer Limits when applicable.** Cancer is limited to a maximum per term of \$500,000 when applicable
6. **Member Shared Responsibility Amounts (MSRA).** Eligible needs are limited to the amounts in excess of the MSRA, which are applied per individual member per the plan year.
7. **MSRA(s).** The eligible amount that does not qualify for sharing based on the membership type chosen by the member.
8. **Office Visit/Urgent Care.** Office visits, in particular, primary and urgent, have certain limits and inclusions. Please refer to the Appendix for your specific plan.
9. **Non-Affiliated Practitioner.** Services rendered by a non-affiliated practitioner will not be eligible for sharing nor will any amount be applied to your MRSA unless specified differently in the plan details contained herein..
10. **Organ Transplant Limit.** Eligible needs requiring organ transplant may be shared up to a maximum of \$150,000 per member. This includes all costs in conjunction with the actual transplant procedure. Needs requiring multiple organ transplants will be considered on a case-by-case basis.
11. **Cost Sharing for Pre-Existing Conditions.** Cost sharing is not available for pre-existing conditions for the first two years of membership.
12. **Overnight Sleep Testing Limit.** All components of a polysomnogram must be completed in one session. A second overnight test will not be eligible for sharing under any circumstance. Overnight sleep testing must be medically necessary and will require pre-authorization (see item 8). Allowed charges will not exceed the Usual, Customary, and Reasonable charges for the area.

Other Resources. Needs do not qualify for sharing to the extent that they are payable by an institutional source such as insurance, VA, Tricare, private grants, or by a liable third party (primary, auto, home insurance, educational, etc.). If the member does not cooperate fully, the need will not be eligible for sharing. The MRSA's are waived up to the maximum MRSA's per membership type only if a liable third party or institutional source pays on the member's behalf. Sharing of monthly contributions for a need that is later paid or found to be payable by an institutional source or a liable third party will automatically allow Unity HealthShareSM full rights to recover from the member the amounts shared on their behalf.

See Appendix A below for Additional Sharing Limits by Plan Level

APPENDIX A: PLAN DETAILS

PPO Network	Multiplan PHCS Specific Services		
PLAN Level	VALUE ²	PLUS ²	PREMIUM ³
Preventative Care	100%	100%	100%
Telemedicine***	100%	100%	100%
Primary Care (PCP)	1 per Year* \$20 Consult Fee	3 per Year* \$20 Consult Fee	5 per Year* \$20 Consult Fee
PCP Chronic Visits	n/a	n/a	Included @ PCP
Urgent Care	n/a	1 per Year* \$20 Consult Fee	2 per Year* \$20 Consult Fee
Labs & Diagnostics*	Preventive Only	PCP & Urgent Care**	PCP & Urgent Care**
X-rays**	Preventive Only	100%**	100%**
Rx Discount	Included	Included	Included
Pediatrics	Preventive Only	Preventive Only	As Primary Care
OB/GYN	Preventive Only	Preventive Only	As Primary Care
UNITY HealthShare^{1,4,5}			
Hospitalization	Included	Included	Included
In-Patient Surgery	Included	Included	Included
Out-Patient Surgery	Included	Included	Included
Specialty Care ⁸	n/a	n/a	\$75 Consult Fee (100% after MSRA)
Emergency Room ⁶	Full MSRA	\$500 MSRA	\$300 MSRA
Maternity ⁷	n/a	n/a	\$5,000 Max
Per Incident Maximum Limit	\$150,000	\$250,000	\$500,000
Lifetime Maximum Limit	\$1,000,000	\$1,000,000	\$1,000,000
<p>*Annual Physical unavailable until 9 months after effective date; Lifestyle lab testing not included. **\$25 Read-fee applies for X-rays at urgent care, per X-ray read (rate may vary by city). ***Telemedicine services not available in some states.</p> <ol style="list-style-type: none"> Pre-existing conditions have a 24-month waiting period Surgical benefits are not available for the first 6 months Surgical benefits are not available for the first 2 months Cancer coverage is provided after 12 months of continuous coverage, if a pre-existing cancer condition did not exist prior to or at the time of application Qualified dependents are under the age of 20. Ages 20-26 can qualify as a dependent, if proven to be a full-time student ER visits are subject to review, and are meant only for life threatening situations. Maximum out-of-pocket is \$300 or \$500 depending on plan chosen Maternity benefits are not available for the first 10 months The Consult Fee is in addition to the cost of your specialty visit and does not apply toward your annual MSRA 		<p>Administrative and Conditional Fees:</p> <ul style="list-style-type: none"> \$125 one-time application fee per enrollment Add \$60 for persons who smoke Add Additional \$130 per member for additional \$500,000 per incident rider <p>Unity HealthShare plans do not promise to pay medical claims, but follow standard claim eligibility review protocols described in plan.</p> <p>Products NOT available in: AK, HI, MD, ME, PR, WA, WY; subject to change w/o prior notice.</p>	

APPENDIX B: TERMS, CONDITIONS, & SPECIAL CONSIDERATIONS

1. The Welcome Kit you received electronically includes this Member Guide, your Membership Card(s), a Welcome Letter, and important information to activate your membership and any applicable accessory services.
2. Keep your Membership Card with you at all times to present to a provider to confirm eligibility.
3. The ACA is subject to change at any time; 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 Member 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. Because more than 80% of primary medical conditions can be resolved by your telemedicine provider, Members must always call the telemedicine provider first to receive medical attention.
8. Telemedicine phone consultations are available 24/7/365, with face-to-face internet consultations available between the hours of 7 a.m. and 9 p.m., Monday – Friday.
9. Telemedicine does not guarantee that a prescription will be written.
10. Telemedicine does not prescribe DEA-controlled substances, non-therapeutic drugs, and certain other drugs which may be harmful because of their potential for abuse. Telemedicine doctors reserve the right to deny care for potential misuse of services.
11. Durable Medical Equipment (DME) – crutches, etc. – is not included in your Plan. Members will be charged for DME at time of service.
12. Alera cannot guarantee that a provider will accept an Alera Plan if the Member fails to contact the Alera Concierge Service first.
13. Member Care Specialists are available to assist you, Monday through Friday, 8 a.m. to 8 p.m. ET at (844) 834-3456. If you call after hours, follow the prompts.
14. At the time of service, payment of \$20 (on average) is due for the consultation, and a \$25 read fee for X-rays, per X-ray read, if needed. Consult fees vary in different states and may be higher in some cities, including but not limited to, New York City, Chicago, Detroit, Miami, Sacramento, Los Angeles, and San Francisco.
15. Plans may vary from state to state. Providers may be added or removed from Alera's network at any time without notice.
16. If you become sick while traveling within the U.S., contact your telemedicine provider first. If directed by the telemedicine doctor to seek further treatment, visit www.UnityHealthshare.com and click on "Network" to search by city, state, or zip code for a list of the nearest in-network providers.
17. Not all geographical areas are serviced by 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.
18. If an urgent care facility is used for a primary care visit for sick care, an additional fee of \$40 will be payable at time of service.
19. Alera Healthcare telemedicine partners do not replace the Primary Care Provider.
20. Primary Care is defined as "episodic primary care" or "sick care." Members are responsible for paying a consult fee at the time of service; no consult fee is due for preventive service.
21. Most network facilities are able to accommodate both urgent care and primary care needs.
22. Not all PPO providers accept a AleraCare Plan. While Alera offers one of the largest PPO networks in the country, some providers may not participate. Provider network online search databases are updated per their own schedule and may be out of synch with your healthcare, specialty care, or hospital provider.

DISCLOSURES

1. 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 Unity programs are NOT insurance. Alera Healthcare/Unity HealthShareSM 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 cover 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)	HCSM	Health Care Sharing Ministry
CMS	Center for Medicare and Medicaid Services	MEC	Minimum Essential Coverage
DEA	Drug Enforcement Administration	PCP	Primary Care Provider
DME	Durable Medical Equipment	PPO	Participating Provider Organization
DPCMH	Direct Primary Care Medical Home Plans	UC	Urgent Care

APPENDIX C: LEGAL NOTICES

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

GENERAL LEGAL NOTICE

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

STATE SPECIFIC NOTICES

Alabama Code Title 22-6A-2

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

Arizona Statute 20-122

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

Arkansas Code 23-60-104.2

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

Florida Statute 624.1265

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

Georgia Statute 33-1-20

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

Idaho Statute 41-121

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

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

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

Indiana Code 27-1-2.1

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

Kentucky Revised Statute 304.1-120 (7)

Notice: Under Kentucky law, the religious organization facilitating the sharing of medical expenses is not an insurance company, and its guidelines, plan of operation, or any other document of the religious organization do not constitute or create an insurance policy. Participation in the religious

organization or a subscription to any of its documents shall not be considered insurance. Any assistance you receive with your medical bills will be totally voluntary. Neither the organization nor any participant shall be compelled by law to contribute toward your medical bills. Whether or not you receive any payments for medical expenses, and whether or not this organization continues to operate, you shall be personally responsible for the payment of your medical bills.

Louisiana Revised Statute Title 22-318,319

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

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

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

Maryland Article 48, Section 1-202(4)

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

Mississippi Title 83-77-1

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

Missouri Section 376.1750

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

Nebraska Revised Statute Chapter 44-311

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

New Hampshire Section 126-V:1

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

North Carolina Statute 58-49-12

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

Pennsylvania 40 Penn. Statute Section 23(b)

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South Dakota Statute Title 58-1-3.3

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an

insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payments for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.

Texas Code Title 8, K, 1681.001

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

Virginia Code 38.2-6300-6301

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

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

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This is NOT Insurance. This is Healthcare Cost Sharing.



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