

GAP Healthcare Membership Guidelines

GAP Healthcare is a faith-based medical needs sharing membership. Medical needs are only shared in by the members according to these Membership Guidelines. Our members agree to the **Statement of Standards** and voluntarily submit monthly contributions into an escrow account facilitated by GAP Healthcare acting as a neutral escrow agent between members.

Members agree to live by the lifestyles, values, and traditions addressed in the Bible and agree to adhere to and sign the Statement of Standards based thereon. The membership does not subsidize self-destructive behaviors and lifestyles, but is specifically tailored for individuals who maintain a healthy lifestyle, make responsible health care choices, and believe in helping others. The membership is NOT health insurance.

Statement of Standards

I agree to live a clean and healthy lifestyle and share the following ethical or religious beliefs:

- ✓ I believe in caring for one another.
- ✓ I believe in keeping my body clean and healthy with proper nutrition.
- ✓ I believe preventive healthcare is important in maintaining good health.
- ✓ I believe the use of tobacco, any smoking device or substitutionary smoking device, illicit drugs and excessive alcohol consumption is harmful to the body and soul.
- ✓ I believe sexual relations outside the bond of marriage is morally wrong and marriage is a bond between a man and woman only.
- ✓ I believe abortion is wrong, except in a life-threatening situation to the mother.
- ✓ I believe I am obligated to care for my family and physical, mental or emotional abuse of any kind to a family member or anyone else is morally wrong.

Contact Information

For general information, help with your application, monthly contribution, or medical needs, please contact us.

- PHONE 714-355-9585
- EMAIL info@gaphealthcare.org
- ONLINE www.gaphealthcare.org
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1. The Purpose and Use of the Membership Guidelines

The guidelines are provided as an outline for eligible needs in which contributions are shared in accordance with the Escrow Instructions. They are not for the purpose of describing to potential members what amounts will be shared on their behalf, and do not create a legally enforceable right on the part of any member. Neither these guidelines, nor any other arrangement between members and GAP Healthcare, creates any rights for any member as a reciprocal beneficiary, a third-party beneficiary, or otherwise.

2. Membership Qualifications

(1) BELIEFS AND STANDARDS

Members share a common set of ethical or religious beliefs as outlined in the Member Statement. If at any time during participation in the membership, a violation of the Member Statement is discovered or revealed through the review of the member's submitted medical records, all needs of the member in violation, submitted after the date of service in which the violation was discovered, will be put on hold. The member will be issued an explanation of the violation and allowed 30 days to submit counteracting documentation before being withdrawn from the membership, rendering all needs ineligible. In the event that a member is withdrawn due to a violation of the Member Statement, GAP Healthcare will not return member contributions prior to the date of withdraw, because contributions are submitted for member to member sharing. Member reapplication may be accepted on a case-by-case assessment.

(2) MEDICAL HISTORY

The applicant(s) must meet all criteria set forth in the Membership Guidelines, to be qualified for membership, on his/her application date. If, at any time, it is discovered that a member did not submit a complete and accurate medical history on the membership application, it could result in either a retroactive membership limitation or a retroactive denial of his/her membership. Members may go through the appeals process to have a membership limitation removed by providing medical evidence that they qualify for such removal. Membership limitations and denials can be applied retroactively but cannot be removed retroactively.

(3) APPLICATION, ACCEPTANCE, AND EFFECTIVE DATE

The person must submit a membership application and be accepted into the membership. The membership begins on a date specified by GAP Healthcare which is usually the first of the following month.

(4) DEPENDENT(S)

A dependent may participate under a combined membership with the Head of Household until he/she turns 20 years of age. However, a dependent who is between 20 and 24 years of age may participate in such a combined membership only if he/she is either a full-time student or a full-time service volunteer. Proof of full-time student or full-time service volunteer status is required with his/her membership application. Upon turning 24 years of age, the dependent must submit his/her own application for the membership. Under a combined membership, the

Head of Household is responsible to ensure that each individual participating under the combined membership meets and complies with the Membership Statement and the Membership Guidelines.

(5) MEMBERSHIP UPGRADE AND CANCELLATION

Members desiring to upgrade their current membership type may be subject to the enrollment process to determine eligibility. GAP Healthcare has the sole discretion to approve or decline membership changes. Changes to the membership must be submitted using the Membership Change Form. The form must be received by the 15th day of the current month for changes to be processed for the next month. Approved changes go into effect on the 1st day of the following month.

Members wishing to discontinue participation in the membership must submit a Membership Change Form by the 15th day of the month for the cancellation to apply to the following month or future requested month. Cancellations become effective on the 1st day of the requested month. Contributions will continue to be processed until the cancellation is effective. Should the member fail to follow the Membership Guidelines as they pertain to the membership and later wishes to reinstate their membership, a new application must be submitted for membership as a new applicant.

(6) OTHER CRITERIA

Children between 12 months and 18 years of age may qualify for membership without their parent's mutual participation on a case-by-case basis as determined by GAP Healthcare. In these cases, the child's parent or guardian must complete and sign the membership application and any associated materials for the child, and is responsible to ensure that all application requirements, Membership Guidelines, and Membership Statement are met. Non-U.S. citizens under 65 may also qualify for membership, as determined by GAP Healthcare on a case-by-case basis.

3. Member Contribution

Monthly contribution amount (MCA) is voluntary contribution that is non-refundable. A member's first month's contribution must be submitted with the application. If the membership application is declined, the first month contribution will not be collected or will be reimbursed. Recurring monthly contributions are due on the 1st of each participating month by automatic bank withdrawal. An administrative fee of \$35 will incur for any returned or unpaid contribution by the member's financial institution. On the 1st day of the second participating month that a contribution has not been received, the member is considered ineligible for sharing until that previous participating month's contribution has been received. If a member's monthly contribution is past due for sixty consecutive days from the last participating month's due date, the member becomes ineligible for sharing and the membership will be withdrawn.

As a non-insurance membership, GAP Healthcare or the membership is not liable for any part of an individual's medical need. In the event that the escrow account does not provide for eligible needs submitted for any sharing month, additional contributions may be requested from the membership. The additional contributions requested will be spread equally amongst that month's participating members.

To date, GAP Healthcare has never requested additional contributions from the membership to share in eligible medical needs.

By submitting monthly contributions, members instruct GAP Healthcare to share escrowed funds in accordance with the Escrow Instructions. GAP Healthcare has no gain or loss financially in determining if a need is eligible or ineligible; therefore, members designate GAP Healthcare as the final authority for the interpretation of the Membership Guidelines. By participating in this membership, the member accepts these conditions as enforceable and binding.

4. Membership Types:

GAP has 2 levels of participation: Platinum, Gold. These are called “Membership Types,” “sharing levels,” or “programs.” Different units may participate at different sharing levels. Make your choice prayerfully and wisely, because different programs offer different levels of health cost sharing support.

(1) Platinum membership: \$200 per unit, per month

Assistance up to \$150,000 for a medical incident exceeding \$500 as long as all other Guidelines are met. Any medical expense less than \$500 per incident is the member’s responsibility.

- (a) inpatient or outpatient hospital incidents and surgery
- (b) maternity up to \$20,000
- (c) incident-related doctor’s office visits, medical testing and prescriptions
- (d) \$1,000 per year Healthcare Credit (HC)

(2) Gold membership: \$150 per unit, per month

Assistance up to \$150,000 for a medical incident exceeding \$1000 as long as all other Guidelines are met. Any medical expense less than \$1000 per incident is the member’s responsibility.

- (a) inpatient or outpatient hospital incidents and surgery
- (b) maternity up to 20,000
- (c) incident-related doctor’s office visits, medical testing and prescriptions
- (d) \$500 per year Healthcare Credit

5. Healthcare Credit (HC)

According to data released by the National Center for Chronic Disease Prevention and Health Promotion (CDC), 75% of total health care costs are due to preventable chronic diseases such as type 2 diabetes, hypertension and obesity. Regular doctor visit prevents disease, and periodic preventive screening detects diseases early. This can dramatically reduce healthcare costs and improve cure rates. GAP believe that Preventive care is essential. For this reason, GAP Healthcare membership provides HC to all members for preventive screening. It can also be used for any healthcare needs including doctor visits, blood tests, X-ray, MRI, dental treatment, psychotherapy, chiropractic, acupuncture, prescription drugs, etc. that member feels necessary to maintain a good health according to the Guidelines. [

(1) Platinum membership: \$1,000 per unit, per anniversary year

- Unused credit up to \$1,000 may roll-over to the following anniversary year.

(2) Gold and Silver membership: \$500 per unit, per anniversary year

- Unused credit will be forfeited on the anniversary date.

6. Eligible Needs

The member's provider, or the member, must submit a request for sharing in the manner and format specified by GAP Healthcare. This includes but is not limited to: Needs Processing Form, industry standard billing forms (CMS 1500 and/or most recent UB form), or itemized statements, if billing forms are not available. If an itemized statement is being submitted for a need(s), the statement must have: Provider's tax ID and name, diagnosis code (DX), procedure code (CPT), billed charges, and date of service (DOS). This is the minimum acceptable information that GAP Healthcare requires regarding an itemized statement submitted for the sharing of a member's need(s). Additionally, medical records and paid receipt may be requested if applicable. All payments are shared up to the Medicare payment schedule less MRA and in accordance with the Membership Guidelines.

(1) ER VISITS, EMERGENCY SURGERIES, PROCEDURES OR TESTS

Non-emergent use of the emergency room is ineligible. 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.

(2) MEDICAL TOURISM

If a member chooses to leave the United States specifically for the purpose of receiving healthcare in another country, the member must first contact GAP Healthcare. All medical procedures outside of the United States must be pre-authorized by GAP Healthcare in order for that need to be considered eligible for sharing.

All other medical procedures/treatments received outside of the country (e.g. vacation) NOT related to medical tourism will be subject to eligibility requirements.

If a member is treated outside the United States, the entire itemized medical bill must be translated into English and converted into U.S. dollars. The member must review the medical bill and assume responsibility for all needed charges as a self-pay patient. Finance charges and currency exchange fees are not eligible for sharing.

(3) CASE MANAGEMENT

In the event a member's condition is expected to be, or is, of a serious nature, GAP Healthcare reserves the right to arrange for case management to oversee the treatment of the individual. GAP Healthcare may alter or waive normal Membership Guidelines provisions when expecting a cost effective result, without sacrificing the quality of care. The use of case management is voluntary for the member; however, non-compliance of the case management's recommendation could result in the need, or related needs, to be ineligible.

7. Pre-existing Conditions

A pre-existing condition is any medical condition for which you experience signs, symptoms, testing or treatment before joining GAP Healthcare. (Routine or maintenance medications are considered treatment.)

For example, if you have a stent that was inserted for a heart condition, the stent is considered treatment and your heart condition is pre-existing.

A condition is no longer considered pre-existing if you have experienced one year without signs, symptoms, testing or treatment (including no maintenance medication) for that condition and it is documented by your official medical records. In contrast, cancer is no longer pre-existing if, after your doctor has pronounced you as cancer-free or cured, you have gone five years without any signs, symptoms, testing or treatment.

We distinguish between pre-existing conditions in an “active” incident and conditions in “maintenance” treatment. Medical bills cannot be shared if, at the time you join GAP, the bills are for pre-existing conditions that are actively undergoing treatment other than with maintenance (routine) medications. If there is any question about whether you are in an active incident, GAP will request your official medical records. If you have gone at least 90 days without testing or treatment and your doctor states that you are cured or on a maintenance treatment regimen, bills for any new incident related to the pre-existing illness are eligible for sharing according to the information below.

If these criteria are met, Platinum and Gold members only can receive assistance with medical bills for pre-existing conditions according to the following schedule:

- ✓ In the first year of membership, bills incurred for a pre-existing condition are NOT eligible for sharing.
- ✓ In the second years of membership, bills incurred for a pre-existing condition are eligible for 50% sharing after MRA up to \$20,000.
- ✓ In the third years of membership, bills incurred for a pre-existing condition are eligible for 75% sharing after MRA up to \$50,000.
- ✓ After the third year of membership, the condition is no longer considered pre-existing.

8. Waiting Periods and Partial Sharing

- (1) Needs within the 90-day waiting period, which begins on the 1st day the membership becomes active, are shared 50% after MRA up to \$10,000.
- (2) Cancer diagnosis, cancer testing, or treatment within the first 12 months of the member’s effective date will be shared 50% after MRA up to \$30,000.
- (3) Healthcare Credit may not be reimbursed during the first 6 months after the membership effective date. (After the 6months waiting period, the Healthcare Credit (HC) can be shared retroactively from the effective date.)

(4) Extreme sports or activities perceived as having a high level of danger. Any needs caused by extreme sports is shared at 50% after MRA up to \$50,000. These activities often involve speed, height, a high level of physical exertion, and highly specialized gear. Extreme sports may include but are not limited to: (Surfing, Cycling, BMX, Free Climbing, Bicycle Polo, Bungee Jumping, Hot Air Ballooning, Ice Climbing, Indoor Skydiving, Inline Skating, Motorcycle Racing, Mountain Biking, Rock Climbing, Scuba Diving, Skateboarding, Ski Jumping, Surfing, Windsurfing etc.)

(5) **OUTPATIENT THERAPY**

Physical therapy is only eligible if the need is associated with an eligible surgery or eligible accidental injury after the first 12 months from the membership effective date.

(6) **TEMPORARY LONG-TERM CARE**

Long term care or skilled nursing facility use is eligible if treating an injury or illness. Care may not exceed 30 visits or 30 days each year. All services must be rendered by a skilled or licensed medical professional.

9. Ineligible Needs

Needs arising from any one of the following are ineligible under the Escrow Instructions:

- Any need for which there was a pre-existing condition within 12 months prior to member's effective date, are ineligible for the first 12 months of membership.
- 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, etc.
- 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 professional
- Procedures or treatments that are not recognized and approved by the American Medical Association (AMA) or that are illegal. This includes procedures not approved by the AMA for a given application, procedures still in clinical trials or procedures that are classified as experimental or unproven interventions and therapies.
- Risk assessment testing, including but not limited to genetic testing and counseling.
- Treatment, care, or services that are not medically necessary or appropriate. Medical necessity is determined by a licensed medical professional(s).
- Lifestyles or activities engaged in after the application date that are in conflict with the Member Statement.
- Needs for members submitted 6 months after the date of service.
- Transportation (e.g., ambulance, etc.) for conditions that are non-life-threatening.
- Any additional expenses for transportation to a facility that is not the nearest facility capable of providing medically necessary care.
- Any additional charges for a private hospital room if a semi-private hospital room is available.

- Congenital birth defect needs beyond \$50,000 limit.
- Elective cosmetic surgery.
- Breast implants (placement, replacement or removal) and complications related to breast implants, including abnormal mammograms, unless related to an otherwise eligible need.
- Elective abortion of a viable fetus/embryo, unless medically necessary to protect the life of the mother.
- Infertility testing or treatment, as well as any birth control measures to prevent conception (e.g., IUD, injectables, patch, etc.)
- Sterilization or reversals (e.g., vasectomy, tubal ligation), sexual dysfunction services, hormone therapy, and sexually transmitted diseases and all associated services.
- Hysterectomy without first obtaining two independent opinions (neither physician may be a partner or another 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 GAP Healthcare.
- Obesity and any complication related to the diagnosis, according to the Centers for Disease Control and Prevention.
- Weight control and management including nutritional counseling for weight loss, weight gain or health maintenance, even if related to a medical condition.
- Circumcisions performed after a newborn is discharged from the hospital, unless it threatens the health of the newborn. This may require review of medical records.
- Chiropractic care, Acupuncture, Dental care, Physical therapy in the first 12 months of the effective date.
- 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.
- Preventive care and immunizations beyond the preventive care allowance limit.
- Medication not requiring a prescription.
- Any condition related to or resulting from seasonal allergies or chronic sinusitis. This includes but is not limited to; routine office visits, injections, immunotherapy, and surgery.
- Custodial, long term care or other care that does not treat an illness or injury.
- Home health care services.
- Chelation therapy.
- Purchase or rental of durable or reusable equipment or devices (e.g., oxygen, orthotics, hearing aids, prosthetics, external braces) including associated supplies or office visits.
- Optometry, vision services, glasses, contacts, supplies, vision therapy, refraction services, and office visits; including medical conditions, for which corrective lenses provide treatment.
- Counseling, testing, treatment, medication and hospitalization for: mental or psychiatric health, learning disability, developmental delay, autism, behavioral disorders, eating disorders, neuropsychological, alcohol/substance abuse, attention deficit or hyperactivity disorder, and psychological conditions.
- Sleep studies due to mental or psychiatric conditions.
- Handling charges, conveyance fees, STAT fees, shipping/handling fees, administration fees, missed appointment fees, telephone/email consultations, and after-hour fees.

- Finance charges and currency exchange fees incurred by medical services received outside of the United States.
- Acts of war.
- Exposure to nuclear fuel, explosives, or waste.
- Over consumption of alcohol, non-prescription drugs or use of illicit drugs, tobacco, vapor or e-cigarettes by a member.
- Self-inflicted or intentional injuries.
- Illness or injury caused by illegal activities of members of the household, includes misdemeanors and felonies, regardless of whether or not charges are filed.
- Diseases due to; tattoos, body piercing, or lifestyle choices, this includes HIV/AIDs and any other STDs.
- Drug testing, unless required by membership.

10. Appeals

If a need is denied as ineligible, and there is a dispute, the aggrieved member may seek reconsideration only through the appeal procedure described herein. Regardless of the potential outcome of an appeal, the existence of this appeal procedure should not be interpreted as creating any expectation of sharing or a legally enforceable right or entitlement since there are no contractual promises of sharing under the Membership Guidelines. Rather, the procedure is a method by which the member can be sure that

GAP Healthcare is sharing monthly contributions in accordance with the Escrow Instructions and Membership Guidelines.

- (1) Most situations can be resolved simply by calling GAP Healthcare.
- (2) Member Services representative will try to resolve the matter, usually within 10 business days.
- (3) Denials due to a retroactive decline for membership or a membership limitation are reviewed again only if the aggrieved party submits a formal appeal.
- (4) The aggrieved party may formally appeal any denied need by contacting the Member Services Department for a complete description of the formal appeal procedure.
- (5) To qualify for an appeal, a member's appeal should address at least one of the following three questions: 01. What information does GAP Healthcare have that is either incomplete or incorrect? 02. How does the member believe GAP Healthcare has misinterpreted the information already on hand? 03. What provision in the GAP Healthcare Membership Guidelines does the member believe GAP Healthcare applied incorrectly?
- (6) Appeals submitted more than 90 days from the date of denial will not be considered.
- (7) The appeal is reviewed first by a supervisor at GAP Healthcare, then, if necessary, by the Appeals Board.

11. Escrow Instructions

GAP Healthcare is an escrow agent that administers voluntary sharing of health care needs for qualifying members. The membership directs GAP Healthcare to hold the member to-member sharing contributions received by GAP Healthcare, in an escrow account at an accredited financial institution.

Those monthly contributions are then distributed for the purpose of medical needs sharing on behalf of the members pursuant to the following Escrow Instructions and in the following order;

- (a) To pay the expenses of operating the membership, including all of the needs necessary for GAP Healthcare to provide for the continued viability of the membership;
- (b) To share eligible needs pursuant to the Membership Guidelines as modified by GAP Healthcare, and as interpreted and applied by GAP Healthcare;
- (c) In the event the membership is to be withdrawn, and after GAP Healthcare determines that the funds held in escrow are sufficient to pay for the items listed above, any remaining funds shall be disbursed to qualified charities, as determined by GAP Healthcare.

GAP Healthcare may deposit or otherwise hold the escrowed contributions in one or more common bank accounts with escrowed contributions from other membership participants, until they are distributed pursuant to these instructions. Interest or other earnings on the escrowed monthly contributions shall become escrowed monthly contributions and shall be held and disbursed pursuant to these instructions. GAP Healthcare shall not be obligated to invest the escrowed monthly contributions, provided; however, that if the escrowed monthly contributions are invested, GAP Healthcare shall not be liable for substandard returns or for losses. Also, as a condition of receiving and distributing the monthly contributions, GAP Healthcare must report to the membership who the monthly contributions are given to.

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 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 an escrow account, not from GAP Healthcare.

GAP Healthcare IS NOT AN INSURANCE COMPANY NOR IS THE MEMBERSHIP OFFERED THROUGH AN INSURANCE COMPANY, AND THE ORGANIZATION IS NOT SUBJECT TO THE REGULATORY REQUIREMENTS OR CONSUMER PROTECTIONS OF ANY STATE INSURANCE CODE. GAP Healthcare IS A NONPROFIT CORPORATION.

This publication or the 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; however, to date GAP Healthcare has shared all eligible medical needs on behalf of 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, whether or not this membership continues to operate, you will remain financially liable for any and all unpaid medical needs.

12. Glossary

Terms used throughout the Membership Guidelines and application are defined as follows:

(1) **ACKNOWLEDGMENTS**

Accepting the truth, facts and existence of statements made in the GAP Healthcare Acknowledgments section of the Application. The GAP Healthcare Acknowledgments are accepted by the member's signature on the application.

(2) **CASE MANAGEMENT**

A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet a member's health care needs through available resources to promote quality, cost-effective outcomes.

(3) **COMBINED MEMBERSHIP**

Two or more family members participating under the same membership.

(4) **COMMITMENTS**

Acceptance, dedication and agreement to adhere to the cause and directives in the Membership Guidelines, the governing document for GAP Healthcare members. The GAP Healthcare Commitments are accepted by the member's signature on the application.

(5) **DATE OF SERVICE (DOS)**

The day medical services were rendered on behalf of a member.

(6) **DEPENDENT**

The Head of Household's spouse or unmarried child(ren) under the age of 20, who are the Head of Household's dependent by birth, legal adoption, or marriage, who is participating under the same combined membership. An unmarried child(ren) ages 20 through 24 years of age may participate in the membership as a dependent if they are a full-time student or a full-time service volunteer.

(7) **EFFECTIVE DATE**

The date an individual membership goes into effect.

(8) **ELIGIBLE**

A qualification for voluntary sharing of contributions from escrowed funds, subject to the sharing limits, Membership Guidelines.

(9) **ESCROW INSTRUCTIONS**

Detailed instructions provided to the escrow agent, GAP Healthcare, to manage the membership escrow account.

(10) **EXPLANATION OF SHARING (EOS)**

Remittance that is issued to the members and their providers once medical needs have been processed, pending or denied. The EOS will state their member responsibility amount (MRA) as well as any amounts shared by the membership on the member's behalf.

(11) MEMBER RESPONSIBILITY AMOUNT (MRA)

The member's out of pocket amount before the membership shares in eligible needs.

(12) INELIGIBLE

A disqualification for voluntary sharing of contributions from escrowed funds, due to the policy set forth in the Membership Guidelines.

(13) MEDICAL TOURISM

When someone who lives in the United States travels to another country to receive medical and surgical care while at the same time receiving equal to or greater care than in the United States, and is traveling for medical care because of affordability, better access to care or a higher level of quality of care.

(14) MEMBERSHIP GUIDELINES

An outline for eligible medical needs in which contributions are shared in accordance with the Escrow Instructions.

(15) MEMBERSHIP LIMITATION

A specified medical condition for which medical needs arising from or associated with the condition are ineligible. An associated condition is one that is caused directly and primarily by the medical condition that is specifically ineligible. The membership limitation will be issued during the application process, and may be subject to medical record review.

(16) MONTHLY CONTRIBUTION AMOUNT (MCA)

Monetary contributions voluntarily given to GAP Healthcare to hold as the escrow agent and to disburse according to the Escrow Instructions.

(17) NEED(S)

Charges or expenses for medical services from a licensed medical professional (M.D., D.O. N.D. Chiropractor, P.T., P.A., etc.) or facility due to illness, accident, or injury for a single member.

(18) NEEDS PROCESSING FORM (NPF)

A form that is required to process medical needs for accidents, injuries or medical conditions that result in a visit to the emergency room. Members must complete and submit this form to GAP Healthcare within 5 days of discharge. The Needs Processing Form may be requested for other medical needs and must be completed and submitted to GAP Healthcare within 6 months of the need to be eligible for sharing.

(19) PRE-EXISTING CONDITION

Any illness or accident for which a person has been diagnosed, received medical treatment, been examined, taken medication, or had symptoms for 24 months prior to the effective date. Symptoms can include but are not limited to the following: abnormal discharge or bleeding; abnormal growth; break; cut or tear; discoloration; deformity; full or partial loss of use; 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 provider. Pre-existing conditions do not apply to office visits/ urgent care.

(20) PREVENTATIVE CARE

Wellness or preventative services that are shared for a membership. A maximum of \$1,000 per unit, per year for Platinum member and \$500 per unit, per year for Gold and Silver members and \$150 per unit, per year for Bronze members.

(21) MEMBER STATEMENT

The religious or ethical standards by which GAP Healthcare members agree to live by during the course of their membership.

(22) UCR (USUAL, CUSTOMARY, AND REASONABLE)

The general cost of medical services in a geographic area, as determined by GAP Healthcare, based on what providers in the area usually charge for the same or similar medical service.