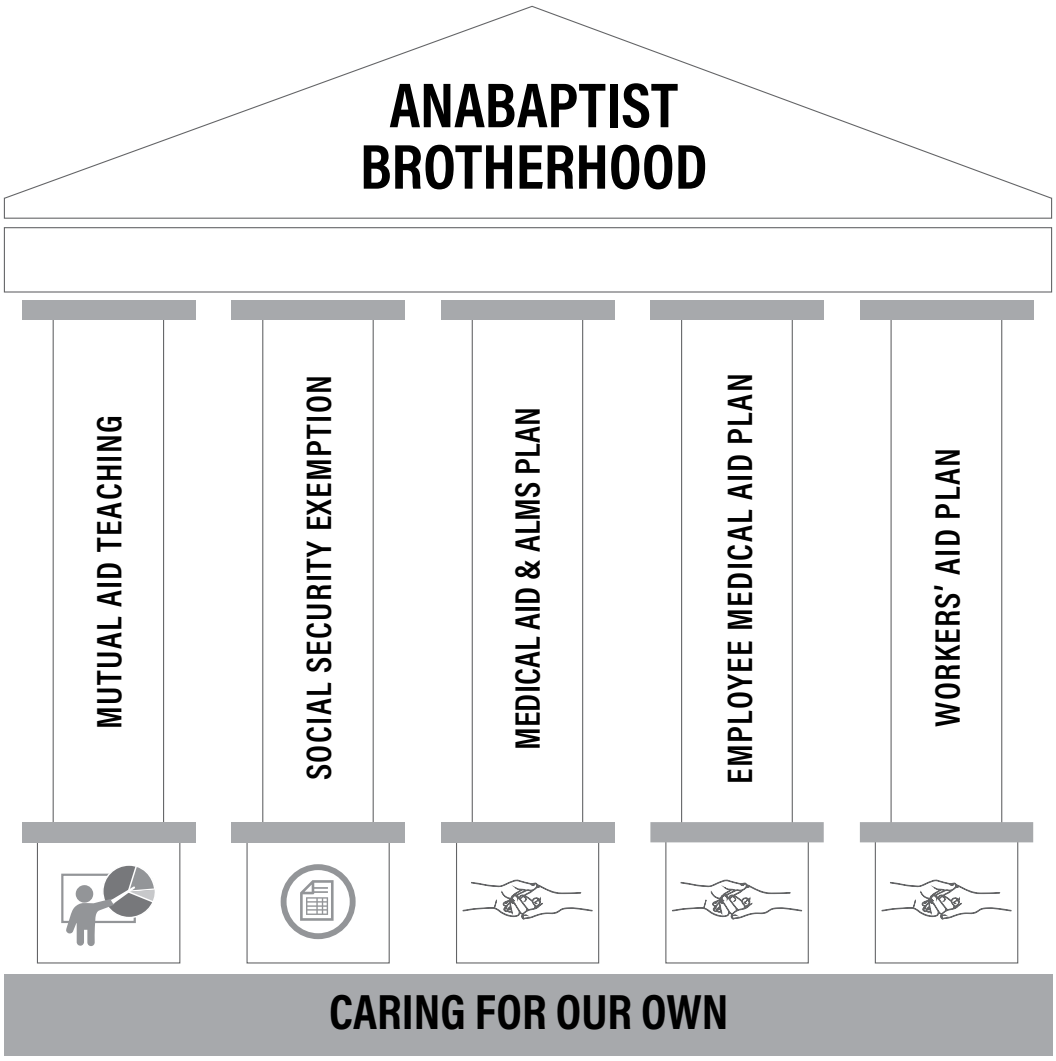
Anabaptist Brotherhood

caring for our own

Men with their teams plow the field of a brother in the church who was laid up with an injury.

Medical Aid & Alms Plan
Complete Guidelines

By this shall all men know that ye are my disciples,
if ye have love one to another.
John 13:35



Mission Statement:
To promote brotherhood mutual aid by providing Biblical two-kingdom teaching and a structured approach to "caring for our own," thereby preserving the Social Security Exemption.

Galatians 6:2
"Bear ye one another's burdens, and so fulfil the law of Christ."

John 18:36
"My kingdom is not of this world..."

Matthew 25:40
"And the King shall answer and say unto them, Verily I say unto you, Inasmuch as ye have done it unto one of the least of these my brethren, ye have done it unto me."

Romans 12:13
"Distributing to the necessity of saints."

1. Provide Biblical stewardship teaching and materials on issues surrounding mutual aid and Social Security.
2. Preserve the IRS Form 4029 Exemption and maintain communication with churches and the government on Social Security issues.
3. The *Medical Aid and Alms Plan* enables Anabaptists to support and share each other's medical and alms burdens. The complexity of the medical system can be frustrating and difficult to navigate. This Plan addresses multiple issues plaguing the economic aspect of the medical system and integrates the old principles of brotherhood mutual aid into the solution.
4. The *Employee Medical Aid Plan* is for Anabaptist-owned businesses that wish to provide medical aid as part of their employee benefits. It is separate from the Medical and Alms Plan for churches and designed for the workplace. This Plan is a mutual aid alternative to commercial medical insurance. (Pending Approval)
5. The *Workers' Aid Plan* is for workers that are exempt from Worker's Compensation. It offers medical aid for workplace injuries, lost wages during recovery, and long-term disability aid.

Medical Aid and Alms Plan
Complete Guidelines

Anabaptist Brotherhood seeks to revitalize the practice of medical aid by combining medical expense sharing with alms support. The Plan equips churches to bear one another's burdens through a comprehensive program and accountable structure without using government programs. It enables deacons to visit the sick and serve the tables in their spiritual role of caring for their own while Brotherhood helps behind the scenes with the complex medical billing issues and financial structures necessary to support deacons ministering on the frontlines. It incorporates medical bill negotiation, fair pricing, and access to alternative care while promoting healthy lifestyles. This integrated approach allows churches to care for both Social Security participants and those who are exempt in a way that is practically effective and brings deep solutions to the troubling aspects of Social Security exemption. Most importantly, Brotherhood is repaving the old highways of mutual aid and rooting their methods in Anabaptist convictions of the Two Kingdom principle and caring for our own—without government.

Key Features

1. Anabaptist Brotherhood's *Medical Aid and Alms Plan* (hereafter referred to as The Plan) is open to members of churches that adhere to the 1632 Dordrecht Confession of Faith or similar Anabaptist confessions.
2. The Plan combines medical and alms sharing into one seamless program. This integration—medical aid and alms working together—is a defining feature of The Plan.
3. Members are responsible for an *Annual Unshared Amount* (AUA) before expenses are shared.
    - Individual: $1,000 base AUA
    - Family: $2,000 base AUA

    After the base AUA, members share 20% of additional eligible expenses until reaching:
    - Individual annual maximum: $4,000
    - Family annual maximum: $8,000
4. Members contribute quarterly based on whether they are enrolled as an Individual or Family and whether they are under or over 65 years of age. Children under 19 are automatically included in the Family rate at no extra cost.

Table 1

Quarterly Medical Contribution

	Under 65	Over 65
Individual	$500	$750
Family	$1,000	$1,500

5. The Plan handles bill processing, repricing, and negotiation to ensure fair and reasonable payments.
6. Members present their *Member ID Card* at the time of service, enabling providers to send bills directly to The Plan for sharing and payment.

Table of Contents

Anabaptist Brotherhood
caring for our own

I. Overview

Purpose of the Plan

Welcome to Anabaptist Brotherhood, (hereafter referred to as Brotherhood) a medical and alms sharing plan. The mission of Brotherhood is to help churches carry the financial burdens of their members who are in need. Our motto is **Caring for Our Own.**

The Principle of Mutual Aid

For more than a century, Anabaptists have described this practice of helping one another as *mutual aid*. Mutual aid is not a secondary belief or a form of socialism—it is a core principle of Scripture and a long-standing tradition of Anabaptism.

Galatians 6:1–10 teaches us to bear one another's burdens (verse 2), while also taking responsibility for our own burden (verse 5). It reminds us of the spiritual law of sowing and reaping (verse 7) and encourages us not to grow weary in well-doing (verse 9). Mutual aid builds *mutual interdependence* within the church, not *individual independence*. As verse 10 says, "Do good unto all men, especially unto them who are of the household of faith."

What This Document Explains

These *Complete Guidelines* explain:

- Who is eligible to join The Plan
- How the Medical Aid and Alms Plan works
- Which medical conditions and services are eligible or ineligible for sharing
- A member's contribution and sharing responsibilities

Before You Join

Please read these *Complete Guidelines* carefully. Many parts of The Plan work together and can only be fully understood as a whole. Each member is responsible for understanding the content before joining. A *Glossary of Terms* is included at the end to help clarify important terms and concepts used throughout this document.

A. Overarching Guidelines

1. The Plan is open to individuals who are members of a church that follows the *1632 Dordrecht Confession of Faith* or a similar Anabaptist confession.
2. The Plan combines *Medical Aid* and *Alms* into one unified system. Each member automatically participates in both programs.
3. The *Medical Aid Plan* helps members by sharing eligible medical expenses, providing guidance on healthcare providers and treatments, and encouraging healthy living through education and resources.
4. The *Alms Plan* provides financial help for widows, people with disabilities, and those with low-income.
5. The Plan serves both Social Security exempt and non-exempt individuals, offering a strong financial solution for each.
6. Full-time staff assist members by negotiating fair prices with providers and offering prompt, personal customer service.
7. The Plan welcomes donations to help cover administrative expenses and support members with large medical needs.

B. Two Ways to Participate in The Plan

Members can join the Medical Aid and Alms Plan in one of two ways:

- As part of a church group with 70% or more participation, or
- As an individual member from a church with less than 70% participation.

1. Church group with 70% or greater participation

- Church Representative
  Each church selects its own representative—usually the deacon or another person appointed by church leadership—to communicate The Plan's information to their local congregation.
- The Contribution Options
  Each church may choose to collect and send contributions through its own collection system, or members may make contributions directly to The Plan.

- Preexisting Conditions
  Members are accepted without an annual expense cap on preexisting conditions.
- Priority for Alms Requests
  Alms requests are given priority over those from churches with less than 70% participation.

2. Individual Member (Church with less than 70% participation)

- No Church Representative Required
- Direct Contributions
  Members make both their quarterly Medical and Alms contributions directly to The Plan.
- Preexisting Conditions
  Preexisting conditions are accepted with an annual expense cap of $10,000.

C. Church Representative Training, Role, and Meeting

Brotherhood provides training so church representatives understand the Plan well. The representative serves as the local contact person and helps members with questions and information. The Plan hosts an annual meeting for church representatives to share feedback, address issues, and recommend policy revisions.

D. Health Education

Brotherhood cares deeply about the health and well-being of all members. Our mission goes beyond sharing medical expenses—it is also to help members honor God through healthy living. Health education is an important part of The Plan. While we help one another with medical costs, we also encourage members to learn how to stay healthy and make informed choices in a medical system that often focuses more on sickness than wellness.

To support this goal, The Plan provides ongoing health education materials and resources. Members are encouraged to keep learning, practice healthy habits, and make lifestyle choices that reflect good stewardship of their bodies. Doing so not only glorifies God but also helps keep overall medical costs lower for everyone. Members are also reminded to be alert to the profit-driven nature of the modern healthcare system and be on guard against excessive and medically unnecessary tests, procedures, and treatments.

E. Medical Aid, not Insurance

Brotherhood offers medical aid and alms, not insurance. Medical aid should never be construed as a contract for health insurance. Each member holds ultimate responsibility and is legally liable for the payment of his or her own medical bills. Brotherhood offers no legal guarantee and shall not be legally liable for the payment of a Member's medical bill. Further, no Member shall be forced or compelled to make sharing contributions. Contributions from Members are voluntary gifts and are non-refundable. If sharing occurs, the shared medical expenses are paid solely from voluntary contributions of Members. Brotherhood serves to facilitate this mutual sharing by managing the Members' pooled funds for those who have eligible expenses.

II. Member Qualifications

A. Christian Belief and Testimony

1. Church Membership

Members must belong to a church that follows the 1632 Dordrecht Confession of Faith or a similar Anabaptist confession.

2. Good Standing

All adult Members, age 19 and older, must be active members in good standing with their church.

3. Belief in the Scriptures

Members affirm their faith in the teachings of the Bible as expressed in these key passages: Deuteronomy 6:4, Colossians 1:15–20, 2 Timothy 3:16–17, John 1:1, Matthew 1:23, Hebrews 4:15, 1 Peter 2:24, 1 Corinthians 15:3–8, Hebrews 7:24–25, Matthew 24:30, John 14:6, Acts 4:12, Isaiah 45:21–23, 1 Corinthians 3:16, Romans 8:14, Ephesians 2:8–10, James 2:17, 26, Romans 12:1, 1 Corinthians 6:18–20, Galatians 6:1–10, Psalm 139:13–17

4. Commitments and Virtues

In light of these Scriptures, Members commit to the following:

- Faithful Sharing: Participate wholeheartedly in sharing medical and alms needs, demonstrating honesty, patience, humility, and love.

- Brotherly Care: Be a brother's or sister's keeper, helping others in the body of Christ according to one's resources and opportunities.
- Healthy Living: Practice temperance and avoid foods, behaviors, or habits that typically lead to sickness or disease.
- Faith-Based Decisions: Make healthcare choices as a matter of Christian conviction, in consultation with trusted physicians, family, or advisors—free from government control that violates conscience.
- Personal Stewardship: Maintain good nutrition and regular exercise to promote health and avoid placing unnecessary burdens on fellow members who share in healthcare costs.

B. The Bedrock Principle

Members agree that the body is a temple of the Holy Spirit and that caring for it honors God. From this conviction grows a desire to steward personal health responsibly. Guided by the Spirit, members strive to make wise decisions about their health, showing respect for their bodies and accountability to others.

III. Alms Plan

Purpose of the Alms Plan

The *Alms Plan* works hand in hand with the *Medical Aid Plan*. This combined structure is a key feature of the program. The Plan operates on principles of local discernment, responsibility, and mutual aid, encouraging churches to work together while avoiding an entitlement mindset.

The Alms Plan does not replace or change the way a local church manages its own alms fund. Instead, it provides an overall framework that allows alms funds to move between churches—so that churches with extra resources can help those with greater needs.

A. General Alms Plan Guidelines

1. **Individual Responsibility**

   Each person should carry their own financial burden as much as they are able.

2. **Church Responsibility**

   Each local church should help its members, bearing one another's burdens as much as they are able.

3. **Brotherhood's Role**

   After individuals and churches have done their part, the *Alms Plan* provides a larger umbrella—linking many churches together to share remaining financial alms needs.

4. **Areas of Assistance**

   The Alms Plan provides financial help for:
   - Widows and widowers
   - Low-income households
   - Individuals with disabilities or congenital conditions
   - Members needing help with their Annual Unshared Amount (AUA) or their Quarterly Medical Contribution

5. **Connection to the Medical Aid Plan**

   The Medical Aid and Alms Plans are connected and cannot be used separately.

6. **Independence from Government Programs**

   The Alms Plan does not expect or require churches to use government programs such as Medicare or Medicaid to cover alms-related expenses.

7. **Local Church Alms Funds**

   Each church continues to operate its own alms fund and care for local needs as much as possible. When additional help is needed, the church may request support from the Alms Plan.

8. **Request Process**

   Church leaders discern if alms assistance is needed. To receive Alms assistance, request an Alms Request Form from the office and submit the form.

9. **Distribution of Funds**

   When assistance is approved, funds are distributed quarterly—either to the church deacon or directly to the individual in need.

10. **Catastrophic Medical Needs**

    Medical bills exceeding $100,000 are funded through the Alms Plan.

11. **Member Contributions**

    The Alms Plan collects quarterly alms contributions from all members.

12. **Donations for Catastrophic Needs**

    Additional alms donations are accepted to help cover major medical events or other large needs.

13. **Priority for Participating Churches**

    Alms requests from churches with 70% or greater participation are given priority over requests from churches with lower participation.

B. Quarterly Alms Contribution and Income Tiers

The Quarterly Alms Contribution is based on the total cost of the Alms Plan from the previous year, divided among all members.

Each household's contribution is tiered according to its income level, using the Adjusted Gross Income (AGI) from line 11 of the household's most recent Form 1040 tax return.

Quarterly Alms contributions are due on the first day of each quarter. The Plan operates on the honor system, trusting each head of household to give the amount that matches their income tier. Members are not required to submit or disclose their tax return.

Table 2 below lists seven income tiers. Members with greater financial ability carry a larger portion of the shared burden—both a responsibility and a privilege within the brotherhood community.

Table 2

Quarterly Alms Contribution

Income Tiers	Rate
$1–$25,000	$55
$25,001–$50,000	$115
$50,001–$75,000	$170
$75,001–$100,000	$255
$100,001–$150,000	$560
$150,001–$200,00	$790
$200,001 and above	$1,015

C. Eligible Alms Expenses

Alms expenses are **not** subject to the Member's *Annual Unshared Amount (AUA).* Alms expenses can be shared even if the AUA has not yet been met or paid.

The following needs are eligible for sharing under the Alms Plan:

1. **Widows and widowers** – Financial assistance to help meet essential living needs.
2. **Low-Income Members** – Support for basic needs such as food, housing, and utilities when income is low.
3. **Disability-Related Care** – Assistance for rehabilitation therapies and treatments connected to a disability.
4. **Durable Medical Equipment (DME)** – Equipment needed due to a disability, such as mobility aids or specialized medical devices.
5. **Birth Defects and Congenital Conditions** – Financial help for medical care or treatment of birth defects and related conditions.
6. **Genetic Testing and Screenings** – Financial assistance for genetic conditions.

7. **Annual Unshared Amount (AUA)** – If a medical incident is overwhelming for a household, the AUA can be paid by the Alms Plan.
8. **Quarterly Medical Contribution** – If the Quarterly Medical Contribution is overwhelming for a household, it can be paid by the Alms Plan.

D. Requesting Alms Assistance

Members who need help with eligible Alms expenses must follow the process below before submitting a request for financial assistance. **All Alms requests must come through church leaders.**

1. **Start with the Member and Family**
   The Member and their immediate family should contribute toward the expense as much as they are able. However, this responsibility should not become an overwhelming or impossible burden.
2. **Then Involve the Local Church**
   The Member's congregation is expected to assist using its own alms resources, as much as it is able.
3. **Request Help from the Alms Plan**
   After the member and church have both done their part, the Alms Plan is available to help with remaining needs.
   - The local church leaders discern whether help is needed and submit a request on behalf of the Member using the Alms Request Form.
   - Each request is reviewed case by case, with input from the local leaders.
4. **Alms Contribution Waiver for Recipients**
   Members who received Alms assistance are not required to make Quarterly Alms Contributions within the same period.

E. Social Security, 4029 Exemption, and Savings

1. **Purpose and Support**
   The Alms Plan provides important support for both members who are on Social Security and those who are Social Security exempt (SSX). After a church provides financial aid out of their own alms resources as much as they are able, the broader Alms Plan steps in to help members with additional financial needs. This shared network of like-minded churches enables congregations to care for their own people sustainably—without dependence on government programs during financial hardship or crisis.
2. **Responsibility to Save**
   Being exempt from Social Security (under IRS Form 4029) carries a serious personal responsibility. Members who are exempt are expected to save for their future needs—especially for medical and living expenses in their later years. This savings practice strengthens the community's ability to care for one another in times of need and ensures that Members remain financially prepared for the future.
   - SSX Members are required to save at least 8% of their annual income each year and report this savings to Brotherhood.
   - Savings Accounts
     SSX Members must maintain an individual savings account with a reputable financial institution of their choice.
     Funds may be held in a self-directed IRA, a long-term savings account, or applied toward extra debt payments on an appreciating asset such as a home or property.
     Anabaptist Brotherhood does not act as an investment organization and does not provide investment advice.
   - Annual Long-Term Medical Reserves Report
     Each SSX Member must submit a **Long-Term Medical Reserves Form** each year.
     - The Member must report saving at least 8% of their previous year's Adjusted Gross Income (AGI) as listed on their Form 1040.
     - Members are not required to submit a copy of their tax return; The Plan operates on the honor system.
     - Members will receive the Long-Term Medical Reserves Form by October 15th and must submit it by December 15th. Failure to submit the annual Long-Term Medical Reserves report results in termination of membership.

IV. Medical Aid Plan

The *Medical Aid Plan* offers a comprehensive way for Members to share one another's medical expenses.

Beyond sharing costs, The Plan also

helps Members navigate today's complex medical system—providing guidance on choosing affordable providers, treatments, and facilities.

General Guidelines

1. **Bill Negotiation and Payment**
   The Plan provides fair and reasonable bill negotiation and payment services to help ensure that Members receive healthcare at fair prices.
2. **Health Education**
   Health education is a key part of The Plan. Members receive ongoing information and encouragement to live healthy lifestyles, including a free subscription to *Our Health* magazine, published by Anabaptist Health Ministries.
3. **Provider Network**
   The Plan helps Members find hospitals, providers, and clinics that offer fair pricing and quality treatments, therapies, and procedures.
4. **Quarterly Contributions**
   Contributions for both the Medical Aid and Alms Plans may be made through church offerings or directly from individual members.
5. **Children Included**
   Children under the age of 19 are automatically included in the Family Plan at no additional charge.
6. **Membership Fee**
   A onetime sign-up fee of $100 is required per household, unless joining with a church that donated its existing medical aid reserves.
7. **Church Participation**
   Churches joining with 70% or greater member participation are expected to contribute their existing medical aid (not alms) reserves to The Plan, helping to maintain strong financial stability.
8. **Catastrophic Medical Expenses**
   Medical expenses exceeding $100,000 are funded by the Alms contributions.
9. **Financial Reserves**
   Brotherhood aims to build financial reserves equal to 10% of annual contributions to ensure long-term sustainability.
10. **Supporting Pledges**
    The Plan relies on pledges from financially able individuals to provide a cash reserve of $1,000,000 for catastrophic needs.

V. Medical Plan Highlights

A. Annual Unshared Amount (AUA)

The **Annual Unshared Amount (AUA)** is the portion of eligible medical expenses that a member must pay each year before any bills are shared through The Plan. The AUA resets every 12 months on the Member's *Effective Date*.

The Plan uses the following structure:

- Individual: Base AUA of $1,000
- Family: Base AUA of $2,000

After the base AUA is met, Members are responsible for 20% of additional eligible expenses until they reach the maximum AUA:

- Individual Maximum: $4,000
- Family Maximum: $8,000

Example A:

A family incurs $22,000 of eligible medical expenses in a 12-month period.

- Base AUA: $2,000
- 20% of remaining $20,000 = $4,000
- Total AUA: $6,000

Example B:

A family incurs $32,000 of eligible medical expenses in a 12-month period.

- Base AUA: $2,000
- 20% of remaining $30,000 = $6,000
- Total AUA: $8,000 (maximum reached)

Once a Member's maximum Annual Unshared Amount (AUA) is reached within a 12-month period, *all remaining eligible medical expenses are shared*. The AUA resets annually on the Member's effective date. This structure encourages Members to take responsibility for a portion of their medical costs while ensuring that larger or unexpected expenses are supported by the wider brotherhood community.

Annual Unshared Amount (AUA) and Continuing Conditions

If an eligible medical condition begins before the Effective Date and continues beyond that date, the AUA remains linked to the original 12-month period in which the expenses first occurred. It is not reset at the new Effective Date for that same condition. A new AUA is not applied for the same condition until that condition extends beyond 12 months, at which point the AUA resets for that condition.

Example: If a pregnancy begins to incur expenses before the Effective Date, all related pregnancy expenses after the Effective Date continue to apply to the original AUA period.

B. The Quarterly Medical Contribution

Quarterly Medical Contributions are based on whether a Member is enrolled as an Individual or a Family. The contribution amount also depends on whether the Member is under 65 or over 65 years of age.

Children under the age of 19 are automatically included in the Family contribution with no additional charge.

Contribution amounts are reviewed each year and may be adjusted based on the overall costs of The Plan.

(See Section X.E. for additional details regarding Members on Social Security and over 65 years of age.)

Table 1

Quarterly Medical Contribution

	Under 65	Over 65
Individual	$500	$750
Family	$1,000	$1,500

C. Health Incentive Discount

The Plan values healthy living and rewards Members who maintain good health. Members age 60 and older may qualify for a 10% discount on their quarterly medical contribution by meeting certain health requirements.

Eligibility Requirements

To qualify for the Health Incentive Discount, Members must meet all of the following requirements:

- Complete an annual primary care wellness visit
- Maintain a healthy weight (BMI < 30)
- Maintain a healthy blood pressure (≤ 130/80)
- Maintain a healthy blood sugar (A1C ≤ 6)
- Maintain healthy cholesterol levels (LDL ≤ 130 and HDL > 45)

Disqualifying Conditions

Members with any of the following conditions **do not** qualify for the Health Incentive Discount:

- Chronic Kidney Disease (eGFR <45)
- Prediabetes (A1C >6)
- Diabetes Type I or Type II
- Heart attack

- Coronary artery disease
- Heart failure
- Atrial fibrillation or flutter
- Stroke or mini stroke
- Rheumatoid arthritis or osteoarthritis
- Cancer
- Dementia
- Chronic obstructive pulmonary disease (COPD) or asthma
- Depression, bipolar disorder, or anxiety
- Osteoporosis or hip fractures
- Tobacco use or vaping

Additionally, any condition for which Brotherhood shares $5,000 or more per year disqualifies the Member from receiving the 10% discount.

How to Apply

To apply for the Health Incentive Discount, contact the Brotherhood office for instructions and to obtain the *Annual Health History Form*.

This incentive encourages Members to take active steps toward maintaining good health and reducing overall medical costs.

D. Preexisting Conditions

A preexisting condition is any condition, diagnosed or undiagnosed, that existed during the two-year period before applying for membership.

1. **Membership Eligibility**
   Applicants are *not excluded* from membership because of preexisting conditions.
2. **Church Participation of 70% or More**
   If at least 70% of a Member's church participates in The Plan, there is no annual limit on sharing for preexisting conditions.
3. **Church Participation Less Than 70%**
   If less than 70% of a Member's church participates in The Plan, sharing for preexisting conditions is limited as follows:
   a. Any condition with an annual expense of $5,000 or more within the two years prior to application or an anticipated cost of $5,000 or more in the next 12 months after application is subject to this $10,000 annual cap.
   b. The $10,000 limit remains in place for the duration of that condition.
   c. A preexisting condition must be free of symptoms, treatment, and medication for 24 months before it is considered cured.

E. Combined Costs

See examples of combined costs in Tables 3 and 4. See specific input costs from Table 1 and 2.

Table 3

For a family (Under 65) with annual income between $50,000 - $75,000	
Onetime – Sign-up Fee	$100
Quarterly Medical Contributions (4x)	$4,000
Quarterly Alms Contributions (4x)	$680
Total Sign-up fee & Contributions	$4,780
Possible Additional Costs	
Base AUA	$2,000
20% AUA	$6,000
Total Maximum AUA	$8,000

Table 4

For an Individual (Under 65) with annual income between $75,000 - $100,000	
Onetime – Sign-up Fee	$100
Quarterly Medical Contributions (4x)	$2,000
Quarterly Alms Contributions (4x)	$1,020
Total Sign-up fee & Contributions	$3,120
Possible Additional Costs	
Base AUA	$1,000
20% AUA	$3,000
Total Maximum AUA	$4,000

VI. Medical Conditions and Services

Medical Conditions and Services that are shareable expenses are referred to as Eligible for Sharing. Medical Conditions and Services that are not shareable expenses are referred to as Ineligible for Sharing. All eligible medical conditions and services are subject to the Member's Annual Unshared Amount (AUA).

A. Eligible for Sharing

1. **Primary Care Visits** - Office visits with licensed providers, including wellness and sick visits, annual physicals, and basic lab tests.
2. **Telehealth services** - Virtual consultations with licensed healthcare providers.
3. **Preventive Primary Care** - Including:
   - Immunizations and vaccinations.
   - Lab tests in addition to basic lab tests
   - Screening mammograms
   - Screening colonoscopies
   - Prophylactic or preventive surgeries
4. **Dental surgery** – When required due to accident or injury.
5. **Chiropractic Care** – Eligible only when:
   - A licensed physician (M.D. or D.O.) has diagnosed the condition and recommended chiropractic care as an alternative to surgery.
   - The physician provides case history, X-rays, and documentation.
   - Care is limited to **20 visits per case.**
   - Tests ordered by chiropractors are **not** eligible for sharing.
6. **Psychiatric Evaluation and Care** – Including associated lab tests and medications up to **six months per case.**
7. **Mental and Behavioral Counseling** – Considered on a case-by-case basis.
8. **Testing and Diagnostics** – Includes X-rays, MRIs, CT scans, ultrasounds, EKGs, lab work, and other diagnostic procedures ordered by licensed providers.
9. **Infertility and Fertility Treatments** – Eligible when treatments are intended to restore normal reproductive function within marriage.
10. **Maternity and Midwifery Services** – Including home births *(see Section VII.).*
11. **Adoptions** – Eligible up to a cap of **$10,000 per adoption** *(see Section VII.E.).*
12. **Hospital and Clinic Services** – Including inpatient, outpatient, and emergency room visits.
13. **Cancer Treatments**
14. **Auto Accident Injuries** – *(See Section VIII.A.).*
15. **Joint Repairs and Replacements**
16. **Ambulance and Medical Transport** – When required between facilities or for emergency transport.
17. **Optical Surgeries** – Procedures to prevent blindness, including cataract, glaucoma, and retinal surgeries.

18. **Corrective Hearing Surgery** – When medically necessary.
19. **Hysterectomy and Endometrial Ablation** – When related to cancer, menopause, or fibroids.
20. **Cosmetic Procedures** – Cosmetic breast reconstruction after breast cancer is eligible for the affected breast, and for the opposite breast when recommended for symmetry.
21. **International Medical Services** – Eligible if approved in *Preferred Providers and Treatments* booklet.
22. **Burn and Wound Care** – Including burdock supplies when administered by a certified Burn Care Team member.
23. **Functional, Integrative, or Alternative Health Care** – Eligible if approved in *Preferred Providers and Treatments* booklet.
24. **Home Care** – Eligible when:
    - Ordered by a qualified provider.
    - The Member is homebound.
25. **Non-Hospital Admission**s – Including skilled nursing, rehabilitation, long-term acute care, or inpatient hospice facilities.
26. **Speech Therapy** – Eligible for up to **10 visits** when post-stroke, post-surgery, or post-trauma. Swallow therapy is also eligible for **10 visits per referral**.
27. **Cardiac Rehabilitation** – Up to **20 sessions** following hospitalization or cardiac procedures, when started within six months of the event.
28. **Therapies** – Includes Physical Therapy (PT), Occupational Therapy (OT), and Osteopathic Manipulation Therapy (OMT), up to **20 combined visits** per case, if prescribed by a licensed provider *(see Section X.J.)*.
29. **Diabetes Treatments** – Including medically necessary supplies for Type 1 and Type 2.
30. **Kidney Treatments** – Including dialysis and other medically necessary treatments.
31. **Sleep Apnea Studies** – Eligible when medically necessary; provider must submit documentation. Studies for insomnia are not eligible.
32. **Prostheses** – Including repair and replacement.
33. **Bariatric (Weight Loss) Surgery** – Eligible up to a **cap of $10,000**.
34. **Prescription Drugs and Medicines** – Includes medications dispensed, infused, injected, or administered by licensed providers.
    - Maintenance prescriptions are shareable for **three months** from the start date or joining The Plan.
    - After three months, members must contact the office to verify eligibility and explore lower-cost options.
35. **Durable Medical Equipment (DME)** – Eligible when ordered by a licensed provider for treatment of an eligible medical need.
    - Rental period limited to six months.
    - One-time purchases may qualify.
    - Must be obtained from an approved DME provider.
    - Motorized wheelchairs, scooters, exercise equipment, and home modifications are not eligible.
36. **Hospice Care** – Limited to 60 days from the first date of service.
37. **Oxygen and Related Equipment**
38. **Medically Necessary Services and Treatments**
39. **Miscellaneous Care** – Including:
    - Dietary counseling
    - Diabetic counseling
    - Lactation counseling
    - Genetic counseling

B. Ineligible for Sharing

The following medical conditions, services, and expenses are not eligible for sharing under The Plan:

1. **Routine Services**
    - Routine vision and optometry care, including nearsightedness, farsightedness, astigmatism, contact lenses, eyeglasses, and refractive services.
    - Routine dental care, including cleanings, fillings, crowns, root canals, caps, implants, and extractions.
    - Routine or maintenance chiropractic care.

2. **Major Procedures and Transplants**
    - Heart, liver, and kidney transplants.
3. **Non-Biblical Lifestyles or Choices**

    Expenses related to non-Biblical lifestyles or choices are not eligible for sharing, including:
    - Abortion.
    - Alcohol and drug-related injuries and illnesses.
    - Sexually transmitted diseases (STDs), including HIV.
        - *Exceptions:* Innocent transmission through blood transfusion, rape, work-related needle stick, or sexual relations within marriage.
    - Injuries or disabilities from illegal occupations or the commission or attempted commission of a crime.
    - Intentionally self-inflicted injuries, including suicide or attempted suicide.
    - Maternity expenses for children conceived outside of marriage.
        - *Exception:* Pregnancy resulting from rape.
    - Illnesses or conditions caused by tobacco use, vaping, or nicotine replacement products.
    - Use of illegal drugs.
    - Abuse of prescription drugs or over-the-counter medications.
    - Sexual relations outside of a Christian marriage between one man and one woman for life.
    - Participation in extreme or dangerous activities that show disregard for personal safety.
    - Participation in professional sports for pay or financial reward.
4. **Alternative or Experimental Care**
    - Vitamins or supplements, unless listed as eligible in the *Preferred Providers and Treatments (PPT)* booklet.
    - Acupuncture.
    - Services from unauthorized providers.
    - Experimental or investigational treatments.
    - Integrative, functional, or alternative medicine not listed as eligible in the PPT booklet.
        - *(See Section IX.A. for more information on* Preferred Providers and Treatments*.)*
5. **Educational and Behavioral Care**
    - Special education expenses.
    - Counseling or treatment for learning deficiencies or behavioral problems, including Attention Deficit Disorder (ADD) or Autism, whether or not connected to another diagnosed condition.
6. **Cosmetic Procedures**
    - Cosmetic or elective procedures such as breast augmentation, reduction, or lift; body or facial contouring; scar revision; tattoo removal; electrolysis; or cosmetic Botox.
    - Revisions of breast reconstruction are not eligible, except when required for infection, necrosis, or lymphoma treatment.
7. **Dental and Periodontal Procedures**
    - Removal of wisdom teeth.
    - Orthodontic or oral surgery (except trauma cases treated within one year of diagnosis).
    - Installation, repair, or replacement of braces, dentures, bridges, or appliances.
    - Treatment for temporomandibular joint (TMJ) disorders, including braces, splints, appliances, or surgeries.
    - Complications or infections resulting from dental procedures.
8. **Hearing Exclusions**
    - Hearing aids, unless hearing loss is caused by an injury or medical condition.
9. **Fertility and Birth Control**
    - Artificial fertility or infertility treatments, including:
    - Artificial insemination.
    - In vitro fertilization (IVF).
    - Embryo adoption.
    - Birth control procedures, such as IUDs and related supplies.
    - Sterilization or reversals (vasectomy or tubal ligation).

10. **Gender and Identity Treatments**
    - Gender reassignment surgeries or hormone treatments related to gender identity disorder.
11. **Non-Medically Necessary or Complication-Related Care**
    - Any procedure or treatment not medically necessary.
    - Complications resulting from any *Ineligible for Sharing* condition or treatment listed in this section.
12. **Transportation and Emergency Services**
    - Non-emergency ambulance transportation when the Member's life or health is not at risk.
    - Overuse of emergency room services incurred for non-emergency conditions.
13. **Miscellaneous Exclusions**
    - Durable Medical Equipment (DME) such as motorized wheelchairs, scooters, exercise equipment, or home modifications *(see Alms Plan, Section III.C.4 for exception)*.
    - Custodial or long-term care services.
    - Educational materials or classes, including:
        - Lamaze classes
        - Breastfeeding classes
        - Early childhood intervention programs
    - Non-prescription (over-the-counter) drugs.
    - Home medical supplies, defined as disposable equipment replaced within six months and used outside of home-health care, including:
        - Wound care supplies
        - Ostomy supplies
        - Custodial care supplies
    - Podiatric orthotics (shoe inserts).
    - Fees for missed appointments.
    - Weight control and management programs, unless part of Primary Care.
14. **Non-Qualifying Sleep Studies**
    - Insomnia
    - Hypersomnia

VII. Maternity and Adoption

A. Maternity

Maternity expenses are eligible for sharing in the same way as any other medical event under the Member's Annual Unshared Amount (AUA).

Married Members must be enrolled in The Plan at least 10 months before the birth to be eligible for sharing maternity-related expenses. If both parents have not been members for 10 months prior to birth, an additional sign-up fee of $1,500 is required.

- This fee is waived for members of churches with 70% or greater participation in The Plan.

Maternity is not considered a preexisting condition, unless known complications existed prior to joining.

Eligible sharing includes:

- Pregnancy and delivery-related expenses
- Antepartum care
- Delivery costs
- Complications for the mother and/or child
- Postpartum care
- Prenatal checkups and up to two ultrasounds (additional ultrasounds must be prescribed by a medical doctor or certified midwife)

To be eligible, maternity care must be provided at a hospital, birthing clinic, or home birth by one of the following qualified professionals:

- Medical Doctor (M.D.)
- Doctor of Osteopathy (D.O.)
- Certified Professional Midwife (CPM)
- Certified Nurse Midwife (CNM)

B. Newborn Status

If a parent is a member at the time of delivery, the newborn is automatically covered from birth.

A Member Application for the baby must be submitted within 30 days of delivery.

The following procedures are eligible for sharing if performed within 60 days of birth:

- Tongue or lip tie revisions
- Circumcision

C. Doctor Visits for well-child care

The Plan values the importance of family and supports care that promotes a healthy start for children.

D. Pregnancies of Unwed Mothers

Maternity medical expenses for children conceived outside of marriage are not eligible for sharing.

The only exception is a pregnancy resulting from rape, provided that the incident is reported to a law enforcement authority.

E. Adoption

Adoption costs are shared with a cap of **$10,000 per adoption**, subject to the Annual Unshared Amount (AUA). A Member Application for the child must be submitted within 30 days of adoption.

VIII. Motor Accidents

A. Safety Equipment and Lifestyle

Medical expenses related to motor vehicle or aircraft accidents are eligible for sharing only after any applicable auto or accident insurance has paid its portion.

Expenses are not eligible for sharing if any of the following apply:

- The member was under the influence of alcohol, illegal drugs, or abused prescription medications.
- The vehicle or aircraft was used in a race, to perform a stunt, or in the commission of a crime.
- The activity involved a willful disregard for personal safety.
- Helmets or seat belts, where legally required, were not worn.

B. Reporting Injuries

Members must notify The Plan promptly to report the details of any motorized vehicle accident that results in injury.

The following documentation may be required to determine eligibility for sharing:

- A copy of the insurance policy for the owned vehicle or aircraft (or the rental or lease contract, if applicable).
- The official accident report.
- Medical records related to the care and transportation of the injured Member(s).
- Information regarding other vehicles or parties involved in the accident.

IX. Providers and Pharmacies

When you visit a medical provider or pharmacy, you don't need to feel uncertain or uncomfortable.

Your **Member ID Card** contains everything a provider or pharmacy needs to know about your membership. Always present it at the time of service.

A. Presenting to providers:

Following these steps helps ensure a smooth, confident experience when receiving medical care.

Step 1: Present your Member ID card

Always present your Member ID card at the time of your visit.

The Card includes:

- Your Household Member ID number
- Billing and contact information
- A clear message about Brotherhood's sharing plan
- The electronic address (ANB25)

Providers can use the electronic address to confirm your eligibility, verify membership, and send bills directly to Brotherhood. If electronic submission isn't available, bills may be mailed to the P.O. Box listed on the card.

Presenting your card builds trust and demonstrates that you are part of a credible sharing plan.

Step 2: Have the provider call our office

If the provider is unfamiliar with Brotherhood or hesitant to accept your Member ID Card, kindly ask them to call the phone number printed on the card. Our staff can quickly explain The Plan and reassure the provider of its legitimacy.

Step 3: Suggest the provider send you the bill

If the provider still declines to bill Brotherhood directly, ask them to send the bill to you instead.

Do not pay the bill yourself.

We will:

- Review and price the bill using reference-based pricing.
- Pay the fair and reasonable amount directly to the provider.
- Invoice you for your Annual Unshared Amount (AUA), if applicable.

Prompt and fair payment helps establish trust with providers over time.

Step 4: Pay at the time of service

If the provider insists on immediate payment, proceed only if both of the following are true:

- You are confident the price is fair and reasonable, and
- The bill is not more than $1,000

Paying at the time of service is common for primary care visits.

If you pay upfront, send a copy of the paid receipt to Brotherhood.

If the expenses are eligible and exceed your AUA, Brotherhood will reimburse you for the shared amount.

B. Presenting to Pharmacies

We want your pharmacy experience to be as smooth and stress-free as possible. That's why we've partnered with **Drexi**, a trusted resource for prescription purchasing. Whether you're stopping by your local pharmacy, ordering medications by mail, or considering manufacturer and international options, Drexi is there to ensure the process is simple, transparent, and affordable. With access to nearly all major pharmacy chains nationwide, members can count on convenience as well as saving around **20% or more** than traditional discount cards or paying cash.

Step 1: Shop for Medications

Drexi gives two convenient ways to find the best option for your prescriptions:

- **Shop Locally:** Visit drexi.com and enter your prescription details to see real-time pricing at nearby pharmacies. You can compare options and choose the one that best fits your needs.
- **Shop by Mail Order:** If home delivery is more convenient, Drexi offers a reliable mail-order service. Simply call **844-728-3479** or place your order through their website, and your medications will arrive right at your door.

Step 2: Present your Member ID Card

Your **Member ID Card** is the key to unlocking Drexi's savings. Whether you're at the pharmacy counter or ordering by mail, always present your card. The card tells the pharmacy that Brotherhood has a contract with Drexi, and your medications should be priced according to those terms.

On the front, bottom right-hand corner of your card, you'll see Drexi's pharmacy identifiers, including the **Bin number, PNC number, and Group number**. These details are what connect you directly to Drexi's pricing system.

In the rare case that a pharmacy does not accept our card, don't worry. You can still purchase your medication—though it will be at the regular price. Afterward, notify Brotherhood, and we'll reach out to the pharmacy to help resolve the issue for the future.

Step 3: Pay for Your Medications

When you pick up your prescription, simply pay at the time of purchase. **You don't need to send a receipt to Brotherhood**—Drexi automatically sends us an electronic record of your purchase. This allows us to review your prescription and check for additional savings.

If the medication is eligible for sharing and you've already met your **Annual Unshared Amount (AUA)**, Brotherhood will reimburse you.

Step 4: Brotherhood Alerts You to Additional Savings

Once we receive your prescription report, our team reviews it to see if there may be even better options—whether through international purchasing or manufacturer programs. If we discover potential savings, we'll reach out to let you know, so you can make an informed choice moving forward.

C. Pre-Notification

Pre-notification helps reduce unnecessary services and hospital stays, improves quality of care, and keeps costs down for everyone in the Plan. It also allows Brotherhood to guide members toward more affordable, higher-quality providers or facilities.

Members must receive pre-notification for:

- Elective procedures expected to exceed $20,000
- Cancer diagnoses or treatments, including medications

Pre-notification provides valuable cost and quality information, but it does not guarantee eligibility or sharing.

In emergencies, no pre-notification is required; however, members should notify the Plan within 72 hours after receiving emergency or urgent care.

D. Preferred Providers and Treatments booklet (PPT)

The Plan publishes an annual Preferred Providers and Treatments (PPT) Booklet that lists recommended providers, clinics, and hospitals—along with their treatments, therapies, and pricing information.

This list is not intended to limit member choice, but rather to help members find the best value for elective procedures and treatments. The PPT Booklet also identifies eligible and ineligible providers and treatments that specialize in functional, integrative, or alternative healthcare.

The first edition of the PPT Booklet will be released by the spring of 2026.

E. Bill Processing and Negotiation

Bill negotiation is a core feature of The Plan that ensures members' medical expenses are paid at prices that are fair, reasonable, and ethical.

The Plan serves as an advocate on behalf of its members, working to protect them from excessive and unjust medical billing. Our approach is rooted in transparency, fairness, and mutual accountability.

Medical billing in today's healthcare system is complex and often inconsistent. Prices for the same procedure can vary drastically between hospitals—even within the same city, without rhyme or reason. The Plan's bill negotiation team works to restore fairness and reason to this process through diligent review, direct provider engagement, and data-driven repricing.

1. Billing Requirements

To be eligible for sharing, all medical bills must be submitted on **industry-standard billing forms** that include the appropriate procedural codes (CPT, HCPCS, DRG, APC, ICD-10, etc.).

These codes allow The Plan to verify the accuracy of billed services and ensure fair evaluation.

(See Section XI.E for more information on billing documentation.)

2. Fair and Reasonable Pricing

The Plan processes all medical bills and makes direct payment to providers on behalf of its members using a **Reference-Based Pricing (RBP)** model.

Reference-based pricing means that every medical bill is evaluated based on actual pricing data—not arbitrary discounts.

Our pricing team uses trusted benchmarks, including:

- Medicare cost and payment data
- Hospital cost-to-charge ratios
- Geographic pricing variations
- Independent medical pricing databases

By analyzing this information, Brotherhood determines a "fair and reasonable" amount that reflects the true cost of services plus a reasonable margin for the provider.

Unlike many insurers or sharing programs, Brotherhood does not use inflated billed charges or rely on "discounted" pricing gimmicks. Instead, we use a transparent, evidence-based approach widely adopted by Catholic and Protestant sharing ministries and other cost-conscious plans across the United States.

This method results in:

- Ethical stewardship of member contributions
- Predictable and sustainable pricing for The Plan
- Honest, data-supported payments to medical providers

3. Balance Billing and Negotiations

Sometimes, after Brotherhood issues a fair and reasonable payment, a provider may still bill the patient for the remaining unpaid balance. This is called balance billing.

When this occurs:

- Do not pay the bill.
- Send it immediately to Brotherhood.

Brotherhood steps in to handle the negotiation process by doing the following. In most cases, a respectful and data-driven discussion resolves the issue quickly.

- Contacts the provider to explain the payment calculation
- Shares independent pricing data and analytics
- Demonstrates the fairness and integrity of the repriced payment
- Works toward a respectful and equitable resolution

If a provider contacts you directly to demand payment, politely respond that:
"Anabaptist Brotherhood is handling my medical bill and will respond on my behalf."

Brotherhood stands fully equipped and committed to support members against unfair billing practices.

4. Collections and Advocacy

Occasionally, a provider or hospital may sell the unpaid balance of a disputed bill to a collection agency rather than working toward resolution.

If this happens:

- Do not contact or pay the collection agency yourself.
- Send the notice to Brotherhood immediately.

Brotherhood will communicate directly with the collection agency on your behalf.

We engage respectfully by providing documentation that demonstrates the legitimacy of the original payment and the unfairness of the inflated balance.

If settlement is reached by offering additional payment, such costs are eligible for sharing within The Plan.

Our goal is to ensure members never face harassment or unfair treatment during billing disputes. Brotherhood advocates every step of the way—from the first bill to final resolution.

5. Building Relationships with Providers

Effective repricing depends not only on data, but also on trust and long-term relationships.

Brotherhood's bill negotiation team invests in professional, respectful communication with hospitals, clinics, and providers across the country. Over time, this builds a reputation for integrity and reliability, which often leads to faster acceptance of payments and smoother cooperation on future bills.

Our approach reflects the heart of mutual aid: honesty, fairness, and good stewardship—ensuring that members receive quality care without bearing the weight of inflated costs.

F. Fair Payment Level.

The Fair Payment Level (FPL) represents the amount that Brotherhood determines to be a reasonable and ethical payment for medical services that are necessary for the care and treatment of illness or injury.

This amount is established using a reference-based pricing (RBP) analysis that considers:

- Medical complexity — any unusual circumstances or complications that require additional time, skill, or expertise.
- Industry standards — what similar providers typically charge for the same services in comparable situations.
- Nature of the illness or injury — the cause and severity of the condition that required treatment.

Brotherhood retains discretionary authority to determine whether healthcare charges are fair and reasonable based on the information contained in the coded medical bill or the associated medical record.

Defined Fair Payment Level

Unless otherwise adjusted for special circumstances, Brotherhood defines the Fair Payment Level (FPL) as:

- Provider services: Charges no greater than 125% of the Medicare allowable rate.
- Facility bills: Charges no greater than 150% of the Medicare allowable rate.
- Excluded charges: Additional fees (such as after-hours, holiday, or weekend fees) that are not CMS-approved are not eligible for inclusion in the Fair Payment Level.

Brotherhood may, at its discretion, adjust the Fair Payment Level upward or downward based on specific medical, geographic, or situational factors to ensure that payments remain fair, transparent, and consistent with the principles of good stewardship.

X. Plan Details

A. Applying for Membership

1. Type of Membership
    a. **Individual:** One person.
    b. **Family:** Two or more people living in the same household.
2. Member Application

    Applicants and dependents must submit a Member Application to be considered for acceptance into The Plan.
    - If the effective date begins mid-quarter, billing is prorated for that quarter.
    - There is a onetime membership sign-up fee of $100 per household.
    - The sign-up fee is waived if the applicant's church has donated its medical aid reserves to Brotherhood.
    - If an applicant omits information that would disqualify them or alter their membership, and that omission is later discovered, medical expenses may not be shared, and membership may be cancelled.
3. Member Acceptance

    Applicants become Members as of the effective date verified in writing.

    When a Member marries, a qualified spouse becomes a Member immediately. The quarterly contribution changes to the Family rate on the first day of the next quarter.

    Use the Member Application to add a spouse and submit within 30 days of marriage.

    Sharing of eligible expenses—including maternity—begins on the marriage date.

B. Spouse and Children

The following family members may be included or added to the household if they meet membership qualifications:

- Spouse
- Biological children*
- Adopted children**
- Children under full legal custody or guardianship**
- Children in legal custody under a placement agreement with a pending adoption**

**See Section X.D. for newborns.*
***See Section X.D. for adoption or custody details.*

C. Children of Members

A child may no longer remain under the parent(s)' household membership after:

- Getting married
- Reaching age 19

In either case, the child must apply for Individual membership.

Exception: Adult children who are severely disabled and remain dependent on their parents for care may continue under the family membership.

D. Adding Children

A child can be added to membership by submitting a Member Application.

Newborns

- Eligible from birth if the application is submitted within 30 days of birth.
- If submitted after 30 days, the effective date becomes the first day of the month following the month that the Member Application was received.

Adopted or Custodial Children

A child may be added upon submission of:

- A valid, signed court order of adoption, or
- A pre-adoption placement order, adoption certification, or petition for adoption.
- If submitted after 30 days, the effective date becomes the first day of the month following the month that the Member Application was received.

If another source is paying for a portion of the adopted child's medical expenses, Brotherhood does not share those same expenses.

E. 65 Years of Age and Older

When the oldest household Member turns 65, the Household contribution automatically switches to the Over 65 rate in the following quarter.

Members on Medicare

1. The Plan shares eligible expenses not covered by Medicare, including the typical 20% co-share.
2. Members 65 and older who are on Social Security and utilize Medicare receive discounts on the Over 65 quarterly contribution (see below) and are responsible for an AUA of $1,000 for an individual or $2,000 for a family.

Age and Status	Discount	Individual	Family
Over 65 (w/SSX)	–	$750	$1,500
Over 65 (w/SS) Medicare Part A	50%	$375	$750
Over 65 (w/SS) Medicare Parts A & B	60%	$300	$600
Over 65 (w/SS) Medicare Parts A, B & D	70%	$225	$450

F. U.S. Citizens who travel abroad for personal or business

Membership qualifications remain the same for U.S. citizens living or traveling abroad.

1. Members must pay the bill up front, obtain an itemized bill in English, provide proof of payment, and submit the documentation to Brotherhood.
   - Currency exchange is based on the payment date.
2. The Plan does not cover medical evacuation or repatriation from a foreign country.

G. Legal Immigrants

Legal immigrants living and working in the U.S. may qualify for membership if they meet the constituency requirements. *(See Section I.A.1.)*

H. Contributions, Cancellations, and Withdrawals

1. Quarterly Contributions

- Due on the first day of each quarter.
- Payable by check, ACH, or credit card.
- If payment is overdue, a notice is sent at 30 days and 60 days.
- If unpaid after 90 days, membership is cancelled.

2. Cancellation Date

- The effective Cancellation Date is the last day of the quarter covered by the most recent contribution.
- Only eligible bills incurred before that date may be shared.

3. Church Standing

- Members who are no longer in good standing with their church and make no effort to reconcile or transition to another eligible church may be cancelled.
- Members transitioning between eligible churches must inform The Plan of their timeline and intent.

4. Voluntary Withdrawal

- Members may withdraw by mail, email, fax, or phone at least 15 days before the desired quarterly cancellation date. (end of any quarter of the year)
- Quarterly contributions are non-refundable.

I. Reapplication After Cancellation

Former members may reapply for membership.

- Prior to approval, **the last unpaid** quarterly contribution and AUA (if any) must be paid.
- The new effective date is the first day of the month following receipt of payment.

J. Licensed Professionals

Eligible testing, treatment, and therapy must be ordered by licensed providers, unless otherwise approved in the *Preferred Providers and Treatments Booklet (PPT)*.

- Medical Doctor (M.D.)
- Doctor of Osteopathy (D.O.)
- Nurse Practitioner (N.P.)
- Physician's Assistant (P.A.)
- Doctor of Podiatric Medicine (D.P.M.)
- Dentist (D.D.S. / D.M.D.)
- Optometrist (O.D.)
- Certified Professional Midwife (CPM)
- Certified Nurse Midwife (CNM)

Diagnosis and treatment must occur within the U.S., except in emergencies or approved cases abroad.

Bills must be submitted on industry-standard forms (CMS-1500 or UB-04/CMS 1450).

(See Section XI.E for details.)

K. Eligibility for Sharing

1. Timing of Determination

Eligibility is determined after services are rendered.

Medical records may be requested to verify diagnosis or billing accuracy.

Refusal to provide requested records renders bills ineligible for sharing.

2. Annual Unshared Amount (AUA)

The Member must pay their AUA before eligible expenses are shared. The AUA resets each year on the Member's effective date.

3. Per-Incident Limits

Sharing limits follow the policies in Section VI.A. – Eligible for Sharing.

4. **Excessive or Unfair Charges**

   Charges determined to be excessive or unfair are ineligible for sharing.

   Brotherhood assists Members with balance bills and reserves the right to determine what constitutes fair and reasonable charges based on industry standards.

   Brotherhood engages directly with providers to resolve any unfair billing disputes on behalf of Members.

5. **Billing Requirements**
   - Delayed Submissions: Bills must be received within 6 months of service. Requested additional information must be returned within 30 days.
     - Note: The Plan uses the date of service, not the billing date, when determining the submission timeline and eligibility for sharing.
   - Improper Submissions: Bills must be properly coded and submitted on industry-standard forms.
   - Excessive Charges:
     - Charges greater than 125% of Medicare allowable rate for Provider services.
     - Charges greater than 150% of Medicare allowable rate for Facility Bills.
     - Non-CMS-approved after-hours, holiday, or weekend fees.

   Brotherhood may, at its discretion, adjust amounts to reflect the Fair Payment Level.

6. **Direct Primary Care (DPC)**

   DPC fees are shareable up to:
   - $250 per year – Individual
   - $500 per year – Couple
   - $750 per year – Family

   These caps apply only to Members using a DPC provider for annual physicals, clinical, and laboratory services instead of submitting those bills through The Plan.

   Standard Primary Care visits (well/sick visits, physicals, and basic labs) are covered without caps.

7. **Occupational or Work-Related Injuries**
   - Expenses for self-employed individuals' work-related injuries or illnesses are eligible for sharing.
   - W-2 employee injuries are not eligible. See Worker's Aid Plan for sharing work-related injuries for W-2 employees.

L. Healthy Lifestyle

A healthy lifestyle begins with learning and growing in knowledge about personal health and developing lifelong habits that support well-being.

Nothing keeps medical costs lower than Members who are personally committed to living healthfully. Eating nutritious foods, staying active, and seeking preventive care all help reduce avoidable expenses.

Each Member plays a vital role in stewarding the shared financial resources of the Brotherhood by making choices that honor God and protect the community's ability to care for one another.

M. Medicare/Medicaid

The Plan does not rely on government-funded programs to cover or reduce Member expenses.

Members are not expected to submit bills to Medicare or Medicaid, except when a Member remains in The Plan after age 65 and on Social Security and chooses to use Medicare Parts A, B, and D.

In that case, Brotherhood will coordinate sharing for eligible costs not covered by Medicare.

N. Conflicts of Interest

To preserve fairness and accountability, the following rules apply:
- Medical bills are ineligible for sharing if the provider (or ordering provider) is related to the Member by blood, marriage, or adoption, or if the Member has a financial interest in the provider.
- If a Member is a medical professional and orders their own testing or treatment, those bills are not eligible for sharing.

O. Travel Incentive for Saving Financial Resources

The Plan offers a travel incentive for Members willing to travel to a provider whose pricing significantly reduces overall medical costs. If a Member chooses to travel for an elective procedure or treatment that saves The Plan money, Brotherhood will credit the Member a percentage of the cost difference between the higher local price and the lower distant provider's price. Members are responsible for paying their own travel, food, and lodging costs. This incentive encourages wise stewardship by rewarding Members who help conserve community resources.

P. Medical Reserve Funds

Brotherhood's reserve funds are held in trust for the Members. If a church with 70% or greater participation withdraws from the organization, it will receive a prorated portion of the reserve funds.

- The prorated amount is determined case by case to ensure fairness based on participation level and contribution history.

Individuals from churches with less than 70% participation who withdraw from the organization do not receive a prorated portion of the reserves.

Q. Amendments to the *Complete Guidelines*

The Complete Guidelines may be updated or amended by decision of the Board of Directors.

Amendments take effect as soon as administratively practical or on a date specifically designated by the Board.

If a Member's medical need occurred before an amendment was adopted, the sharing of expenses for that need will be governed by the Guidelines that were in place at the time the expense was incurred.

Members will be informed of any changes through:

- The quarterly newsletter
- Announcements on the Brotherhood website
- Updated versions of the Complete Guidelines

XI. Office and Billing

A. Bill Payment and Invoice

After your medical bills are processed and paid, you will receive an Explanation of Sharing (EOS) along with an invoice for your Annual Unshared Amount (AUA)—if it has not yet been met—and any ineligible expenses. Invoices are due within 30 days of the invoice date.

B. Going the Second Mile

In the spirit of mutual aid and generosity, Members who are financially able are encouraged to go the second mile by paying more than their share (AUA) of their own bill or invoice.

This is never a requirement but an invitation to live out the Biblical principle: "Freely you have received, freely give." — Matthew 10:8

C. Explanation of Sharing (EOS)

The Explanation of Sharing (EOS) is a summary statement that shows how your medical bills were processed.

It includes:

- The total billed amount,
- The portion shared by The Plan,
- Any adjustments made through repricing or negotiation, and
- The Member's remaining responsibility, if any.

If a bill or portion of a bill is not eligible for sharing, the EOS will include clear notes and explanations.

D. Reimbursement

A **reimbursement** occurs when a Member has already paid an eligible bill and requests repayment from The Plan.

Members may request reimbursement for eligible expenses such as:

- Medical bills
- Adoption expenses
- Out-of-country emergencies
- Prescription costs

Whenever possible, Members should ask medical providers to bill The Plan directly so that Brotherhood can negotiate and pay the provider at a fair and reasonable price. If you must pay at the time of service, you may submit the itemized bill and proof of payment to The Plan for reimbursement. Reimbursements are processed within 30 business days, though additional time may be needed if further billing documentation is required.

E. Provider Forms

For medical bills to be eligible for sharing, providers must submit them using one of the following industry-standard billing forms:

- **CMS-1500** (also known as HCFA-1500) – used for professional services
- **UB-04** – (also known as CMS -1450) used for hospitals or facilities

F. Our Commitment to Privacy

Anabaptist Brotherhood deeply values your privacy and is committed to protecting your personal health information (PHI). Although Brotherhood is not an insurance company and is therefore not legally subject to the federal Health Insurance Portability and Accountability Act (HIPAA), we voluntarily follow HIPAA-like privacy standards to safeguard your information. We use your information only for purposes related to membership, bill processing, and sharing.

We do not sell or share your information for marketing or commercial use.

XII. Governance and Principles

A. Governance

1. The current *Complete Guidelines* govern the program, not the *Complete Guidelines* that were in effect when a Member joined The Plan. The *Complete Guidelines* are final and overrule any verbal statement made by staff regarding The Plan or explanation of polices in other publications such as newsletter or help sheets.
2. Program changes. The guidelines set forth in the *Complete Guidelines* are subject to change. Members will be notified of any major proposed changes 30 days before the change takes effect, including rate changes.
3. The Board of Directors holds the authority to modify the Guidelines. However, proposed major guideline changes will be presented to the representatives for their input at the annual representative meeting.
4. Anabaptist Brotherhood operates in accordance with the Internal Revenue Code's definition of a 501(c)(3) nonprofit corporation. As a 501(c)(3), the ministry annually files a Form 990 with the IRS.
5. The organization is governed by an independent Board of Directors. The Board shall meet regularly to assist the executive team in the execution of the health care sharing mission in service to its Members.
6. The organization uses generally accepted accounting principles (GAAP) and is audited annually by an independent accountant. The audited financial statements are available to the public upon request.
7. The organization follows a conflict-of-interest policy.
8. The organization provides clear communication to Members with a quarterly newsletter, website, and other email notifications and mailings.

B. Health Sharing Principles

1. The organization limits total administrative and program costs to less than 10% of annual revenue.
2. The organization does not expect or require its Members to apply for government assistance or state aid as part of The Plan's sharing process.
3. The organization does not use health insurance agents, health insurance agencies, health insurance brokers, health insurance producers, or health insurance representatives.
4. The organization does not assume any transfer of medical risk from its Members or make any legal guarantee of payment for any expenses.
5. The organization maintains a clear Anabaptist Christian statement of faith and will only accept families and individuals who adhere to the statement of faith as well as the Complete Guidelines.
6. The organization clearly communicates the following information to those who are interested in joining The Plan:
    - Brotherhood is not an insurance company, nor does it offer any insurance product.
    - The sharing of medical costs is completely voluntary, and Brotherhood is not legally liable to pay the costs for medical bills submitted for sharing.
    - All Members will maintain their legal responsibility to pay for the medical bills they incur irrespective of whether Brotherhood facilitates payment through the sharing process.

XIII. Disclosures

General Notice for the following states: **Alabama** Code Title 22-6A-2, **Arizona** Statute 20-122, **Arkansas** Code 23-60-104.2, **Florida** Statute 624.1265, **Georgia** Statute 33-1-20, **Idaho** Statute 41-121, **Louisiana** Revised Statute Title 22-318,319, **Maine** Revised Statute Title 24-A, §704, sub-§3, **Michigan** Legislature Section 550.1867, **Mississippi** Code Title 83-77-1, **Nebraska** Revised Statute Chapter 44-311, **New Hampshire** Section 126-V:1, **North Carolina** Statute 58-49-12, **South Dakota** Statute Title 58-1-3.3, **Tennessee** Code Annotated, Section 48-51-201, **Texas** Code Title 8, K, 1681.001, **Virginia** Code 38.2-6300-6301, and **Wyoming** Statutes Title 26.1.104(a)(v)(C).

Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and its product should never be considered insurance, and neither its guidelines nor plan of operation is an insurance policy. If you join this organization instead of purchasing health insurance, you will be considered uninsured. 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. This organization is not regulated by the States' Department of Insurance, though complaints concerning this Health Care Sharing Ministry may be reported to the office of the States' Attorney General. You should review this organization's guidelines carefully to be sure you understand any limitations that may affect your personal medical and financial needs.

Specific Notice for the following States: **Indiana** Code 27-1-2.1, **Illinois** Statute 215-5/4-Class 1-b, **Missouri** Statute Section 376.1750 and **Wisconsin** Statute 600.01 (1)(b)(9).

"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 OR 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."

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."

Pennsylvania 40 Penn. Statute Section 23(b), "NOTICE: This publication is not an insurance company nor is it offered through an insurance company. This publication does not guarantee or promise that your medical bills will be published or assigned to others for payment. Whether anyone chooses to pay your medical bills will be totally voluntary. As such, this publication should never be considered a substitute for insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always liable for any unpaid bills."

West Virginia; Statute §35-1B-1-6, "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. Complaints concerning this health care sharing ministry may be reported to the Attorney General of your state."

XIV. Medical Expenses for which third parties are responsible.

A. Exclusion of Expenses

Medical expenses incurred by a Member are not eligible for sharing if such expenses are covered by Workers' Compensation, auto insurance, or if a third party is responsible to pay such expenses. For example, if a Member is injured in a car accident, the Member's automobile insurance may provide coverage and an at-fault third party may be liable for the Member's medical expenses. Or an injury occurs at work with a person on Social Security, in which case Workers' Compensation is liable for the Member's medical expense.

B. Waiver of Expense Exclusion
The Plan may, at its sole discretion, waive the foregoing exclusion as applied to specific medical expenses and determine whether such expenses are otherwise eligible for sharing under these Guidelines. However, The Plan has no obligation to waive the exclusion, and specifically reserves the right to exercise or not exercise its waiver discretion.

C. Subrogation Right
If a Member's specific medical expenses subject to the foregoing exclusion are shared through The Plan, then the Member's rights to recover all or part of such medical expenses from an insurer or responsible third party are transferred to The Plan for the benefit of the Members. The Member shall do nothing after incurring such expenses to impair such rights of recovery.

D. Right of Reimbursement
If a Member's specific medical expenses subject to the foregoing exclusion are paid through The Plan and the Member recovers all or part of such medical expenses from an insurer or responsible third party, the Member agrees to contribute those funds to The Plan within 30 days after the Member receives payment from such insurers or responsible third parties.

E. Lien on Third-Party Recoveries
If a Member's specific medical expenses subject to the foregoing exclusion are paid through The Plan and the Member recovers all or part of those medical expenses from an insurer or responsible third party, the Member hereby grants a lien to The Plan for the benefit of the Members on the proceeds of any monetary recovery the Member obtains from any insurer or responsible third party, and the Member agrees to take any actions or steps necessary to secure this lien. To the extent the Member has engaged an attorney to assist in the recovery of medical expenses (such as a personal injury attorney), the Member agrees to inform the attorney of such lien.

XV. Appeals

Brotherhood is a voluntary association of like-minded people who come together to assist each other by sharing medical and alms expenses. It is recognized that differences of opinion will occur and that a methodology for resolving disputes must be available. By signing the Member Application form, individuals agree that any dispute with or against Brotherhood or its associates or employees will be settled using the following steps of action. If a determination is made by Brotherhood and the Member disagrees and believes there is a defensible reason why the initial determination is wrong, then the Member may file an appeal.

A. Impartiality
The Plan serves Members who share in the burdens of fellow Christians. The Plan does not gain financially by determining medical bills are ineligible for sharing among Members. Anabaptist Brotherhood is a not-for-profit corporation, recognized as tax exempt under Section 501(c)(3) of the Internal Revenue Code. Brotherhood has no owners, stockholders, or investors. Brotherhood impartially conducts the purpose of the organization as expressed in these Guidelines.

B. Appeals and Mediation
A Member can appeal bill-sharing decisions with which they disagree. Before appealing, a Member should engage in careful thought and prayer about whether he or she honestly believes an error was made. Nearly all needs can be determined to be shareable or not shareable according to the Guidelines. In matters where the Guidelines may not provide absolute clarity, further clarification will be made according to historical procedure and precedent.

A Member can issue an appeal if:

- the medical records were misread,
- the Guidelines were misapplied, or
- one or more of the Member's providers incorrectly recorded the medical history.

The appeals process is not to be used to request changes or exceptions to these Guidelines.

1. **First Level of Appeal**. Most differences of opinion can be resolved simply by calling and discussing the matter with Brotherhood. After a review and response by Brotherhood, if the Member disagrees with their decision, the Member has 30 days to request a review by an Internal Resolution Committee.

2. **Second Level of Appeal.** If the Member is unsatisfied with the decision of the first-level appeal process, then the Member may request a review by the Internal Resolution Committee, made up of three (3) administrative staff. 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:
   - What information was either incomplete or incorrect?
   - How do you believe Brotherhood misinterpreted the information or situation?
   - What provision in the Complete Guidelines do you believe was applied incorrectly?

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

3. **Third Level of Appeal**. If the Second Level of Appeal is unsatisfactory, the Member can appeal to an Appeals Panel chosen by the Brotherhood's Board of Directors but including only objective and unrelated individuals. The definition of "objective" and "unrelated" individuals is as follows: The Member Appeals Panel will be Members of the organization, but not board members or staff or immediate family members of the same and also not immediate family members or church members of the Member requesting the Appeal. Brotherhood and the Member will both submit a written position statement to the panel. A teleconference will be held where the panel can ask questions of both the Member and Brotherhood. A simple majority vote will carry the decision.

The parties agree that these mediation methods of dispute resolution shall be the sole remedy for any controversy or claim arising out of this agreement, and they expressly waive their right to file a lawsuit against one another in any civil court for such disputes, including using arbitration to enforce a legally binding decision.

XVI. Glossary of Terms

Annual Unshared Amount (AUA) – The dollar amount a Member must pay toward their Eligible Medical Bills during a 12-month period before those bills are approved for sharing. The 12-month period begins on the Effective Date. The Plan uses a Base AUA of $1,000 for Individuals and $2,000 for Families. After the base AUA, the Member pays 20% of eligible expenses until reaching the Maximum AUA of $4,000 for Individuals and $8,000 for Families. After reaching the Maximum AUA, 100% of eligible expenses are shared.

Balance Billing – The remaining portion of a medical bill for which a fair and reasonable payment has already been made. Brotherhood reserves the right, on behalf of its Members, to determine unfair or unreasonable bills based on objective criteria and established standards.

Biblical Christian Marriage – A lifelong union between one man and one woman. *(Genesis 2:22–24; Matthew 19:5; Ephesians 5:22–32)*

Bill Approved for Sharing – An Eligible Medical Bill that meets all criteria for sharing as stated in the Guidelines, including whether the Member's AUA has been met.

Burn Care Team – Individuals trained (though not licensed) in burn and wound care and the use of burdock treatments.

CMS – The Centers for Medicare and Medicaid Services, a national agency that oversees healthcare provider and facility standards.

Cancellation Date – The month and day that membership ends due to withdrawal, failure to follow the Guidelines, or failure to make quarterly contributions.

Date of Service – The date a medical service, procedure, or treatment was performed or provided. Brotherhood uses the date of service, not the billing date, to determine eligibility, timeliness, and sharing periods.

Direct Primary Care (DPC) – A healthcare model in which patients (or Members) pay their provider directly, usually through a monthly or annual fee, rather than through traditional billing. This fee typically covers unlimited office visits, basic lab work, and certain preventive services. DPC emphasizes personal, ongoing relationships between the provider and patient, reduced administrative costs, and easy access to primary care without third-party billing. Members who use DPC providers may still submit eligible expenses for sharing within the limits established by The Plan.

Durable Medical Equipment (DME) – Equipment or devices that are:

1. Durable and reusable
2. Used for a medical reason
3. Typically, only useful to someone who is sick or injured.

   Examples include nebulizers, crutches, oxygen concentrators, leg or arm braces, and manual wheelchairs.

Effective Date – The date membership begins or the date of the most recent change to the Member's AUA. It determines when each 12-month AUA period begins and ends.

Eligible for Sharing – Any test, treatment, procedure, or service that meets the criteria for sharing as defined in the Guidelines.

Eligible Medical Bill – A medical bill that meets the criteria for sharing per the Guidelines.

Excessive or Unfair Charges – Healthcare charges that exceed what is considered fair and reasonable under the Complete Guidelines and are therefore ineligible for sharing.

Explanation of Sharing (EOS) – A statement for Members and Providers that shows how a medical bill was processed. The EOS reports how much was shared, how much was adjusted, and the amount (if any) the Member is responsible for.

Fair Payment Level – Charges for services which are necessary for the care and treatment of illness or injury and priced with a reference-based pricing approach and eligible per the Complete Guidelines.

FDA – The Food and Drug Administration, which ensures the safety and effectiveness of drugs, biological products, medical devices, foods, cosmetics, and radiation-emitting products in the United States.

Illegal Drugs – Drugs which are classified as Schedule 1 in the Title 21 United States Code Controlled Substances Act.

Incident – The occurrence of an illness or an injury of a member, requiring a diagnosis of symptoms and treatment of a specific condition.

Medically Necessary – Healthcare services provided to prevent, diagnose, or treat illness or injury that meet accepted medical standards or sufficient peer-reviewed evidence. Brotherhood may review medical records or request a second opinion to determine medical necessity.

Member – Any individual or family participating in The Plan as an active member, including all dependents under 19 years of age.

Non-Medically Necessary Service – Care, treatment, or services that do not meet the definition of Medically Necessary, or that are not recommended or approved by a qualified provider. Brotherhood reserves the right to review and decline bills deemed non-medically necessary.

Preexisting Condition – Any condition, diagnosed or undiagnosed, that existed during the two-year period before application for membership.

Prosthesis – A device, either external or implanted, that replaces or supports a missing or defective body part. Examples include:

- External prosthetics: Artificial limbs, facial structures, externally worn breast prostheses following mastectomy.
- Implanted prosthetics: Artificial joints, artificial heart valves, artificial eyes/lenses, cochlear implants, surgically implanted breast implants following mastectomy.

Provider Forms – Standard industry billing forms (CMS-1500/HCFA or UB-04/CMS 1450) required for a medical bill to be eligible for sharing.

Quarterly Contribution (or Share) – The amount a Member faithfully contributes each quarter to support the sharing of medical and alms needs.

Sign – An objective observation or finding noted by a medical professional.

Standard of Care – A treatment or procedure accepted by medical experts as proper and widely used for a specific disease or condition.

Standard Primary Care – Healthcare services provided by licensed primary care providers (such as family doctors, nurse practitioners, or physician assistants) that include diagnosis, treatment, and prevention of common illnesses and conditions. Standard Primary Care is billed on a per-visit basis and includes well visits, sick visits, annual checkups, and basic lab tests. These services are eligible for sharing under The Plan without annual caps.

Symptom – A subjective experience or feeling of illness, as described by the patient.

Telehealth – Healthcare services delivered through secure, real-time, two-way audio and video communication between a patient and provider, allowing medical evaluation or treatment from a remote location.

Frequently Asked Questions

1. **What is an Annual Unshared Amount (AUA)?**
   The AUA is the dollar amount a Member must pay toward their Eligible Medical Expenses during a 12-month period. The AUA 12-month period resets on the Effective Date.

2. **What is the AUA for the Plan?**
   The Plan utilizes a base **AUA** of $1,000 of eligible expenses for the Individual and $2,000 of unshared eligible expenses for the Family. After the base **AUA**, members are responsible for 20% of additional eligible expenses until they reach the maximum of $4,000 for the Individual and $8,000 for the Family.

3. **How does a Member meet (or pay) the Annual Unshared Amount (AUA)?**
   Every time you visit a medical provider, present your Member ID card. The card will inform your provider to submit your medical bills to The Plan. The Plan will process, negotiate, and pay the bill. Then the member will receive an invoice from the Plan for the Annual Unshared Amount of eligible expenses and ineligible expenses. Within a 12-month period, once the amount that you pay meets your AUA, the eligible medical bills will be 100% shared.

4. **What is the Quarterly Medical Contribution?**
   Quarterly Medical Contributions are structured by **Individual** or **Family.** See green rows in **Table 1**. Secondly, the contributions are determined by whether a person's age is **Under 65** or **Over 65.** Children under the age of 19 are automatically part of the **Family** without additional contributions.

   Table 1

   Quarterly Medical Contribution

	Under 65	Over 65
Individual	$500	$750
Family	$1,000	$1,500

5. **How does The Plan deal with preexisting conditions?**
   A preexisting condition is a condition with or without a medical diagnosis present in the two-year period prior to application for membership.
   - Applicants are not excluded from membership due to preexisting conditions.
   - If at least 70% of a Member's church participates in The Plan, there is no annual sharing cap for preexisting conditions.

- If less than 70% of a Member's church participates in The Plan, preexisting conditions are shared but with the following limitations.
    - Any condition with annual expense of $5,000 within the last two years or an anticipated expense of $5,000 in the next twelve months is limited to an annual sharing cap of $10,000.
    - The $10,000 annual expense sharing cap remains in place for the duration of the condition.
    - A preexisting condition needs to be free of symptoms, treatment, and medication for a period of 24 months before being considered cured.

6. **Does The Plan include a health incentive discount?**
   Yes, The Plan values a commitment to healthy living and rewards Members for their healthful choices through a health discount of the quarterly medical contribution. The Plan offers a **10% Health Incentive Discount** of the quarterly medical contribution to Members above 60 years of age that meet the healthy living requirements. Qualifying for the health requirements is determined with a doctor's office visit, blood test, and other health metrics. The health requirements are measured annually.

7. **What does the Alms Plan provide financial support for?**
   The Alms Plan provides financial support for widows, people with disabilities, low income, and catastrophic medical events over $100,000.

8. **What is the Quarterly Alms Contribution amount?**
   The Quarterly Alms Contribution amount is prorated across seven income tiers. The tiers are based on the annual household income level, using the Adjusted Gross Income (AGI) from line 11 of the household's most recent Form 1040 tax return.

Quarterly Alms Contribution

Income Tiers	Rate
$1–$25,000	$55
$25,001–$50,000	$115
$50,001–$75,000	$170
$75,001–$100,000	$255
$100,001–$150,000	$560
$150,001–$200,00	$790
$200,001 and above	$1,015

9. **Why is the Quarterly Alms Contribution tiered?**
   The Plan is structured so that those with the responsibility of wealth can carry the bulk of the burden of the widows, people with disabilities, low income, and catastrophic medical costs.

10. **What changes occur when a Member turns 65 years of age?**
    When the oldest Member of the family turns 65 years of age, the Household Family quarterly medical contribution amount switches to Over 65. The Over 65 contribution change occurs in the quarter following the 65th birthday of the oldest person in the Member Household.

11. **What discount does The Plan provide for Members who are 65 or older and not Social Security exempt and utilize Medicare?**
    They receive the following discount of the Over 65 quarterly medical contribution amount:

    a. Members on Medicare Part A receive a 50% discount.

    b. Members on Medicare Parts A and B receive a 60% discount.

    c. Members on Medicare Parts A, B, and D receive a 70% discount.

    If a Member utilizes Medicare A, or B, or C, The Plan shares eligible expenses not covered by Medicare with an AUA of $1,000 for the individual or an AUA of $2,000 for the family.

12. **What happens when an adult child is on the family plan and gets married or turns 19?**
Children of Members may be part of the parents' Member Household until they reach age 19. Within 30 days after the adult child's 19th birthday, he or she must complete the Member Application and become an adult member. In addition, a child may no longer participate under the Family Member Household of the parent(s) after getting married and must apply for their own Family membership.

13. **Is assistance available if a member experiences financial hardship?**
Yes. The Alms Plan functions as a backup plan for those that are struggling financially. If you need financial assistance, contact your deacon or church representative and request assistance from the Alms Plan.

14. **When does a Member need to provide pre-notification for elective surgery or treatment?**
To steward our resources, Members must provide pre-notification for elective procedures that exceed $20,000 or for procedures with estimated cumulative costs that could exceed $20,000. Pre-notification enables the Plan to provide significant knowledge of cost savings or higher quality providers or facilities. Pre-notification of medical bills does not guarantee eligibility or sharing. No pre-notification is needed for emergencies.

15. **How does the Plan relate to Medicare and Medicaid?**
The Plan does not use government-funded programs to cover costs and reduce expenses. It does not expect Members to utilize Medicare or Medicaid to cover expenses, unless a Member stays on the Plan after 65 years of age and is on Social Security and utilizes Medicare Parts A, B, and D.

16. **What is a reimbursement?**
A reimbursement is a member request for The Plan to process an eligible bill you have already paid. Members can seek eligible reimbursement on medical bills, adoption, out-of-country emergencies, or prescription costs.

17. **How should a Member present and pay for medical services?**
Here are the steps to follow to ensure a smooth, confident experience.

    Step 1: Present Your Member ID Card

    Your Member ID Card is designed to make your experience stress-free and more affordable while building trust with the provider. Always present it at the time of your visit. The card includes:

    - Your Household Member ID number
    - Billing and contact information
    - A clear message about Brotherhood's sharing plan
    - The electronic address (ANB25)

    The provider can use the electronic address to instantly confirm your identity, eligibility, and current membership status. They can also use it to send the bill directly to Brotherhood. If they don't have access to the electronic address, they can mail the bill to the P.O. Box listed on the card. Presenting your Member ID card gives the provider confidence that you are with a credible sharing plan.

    Step 2: Have the Provider Call Our Office

    If a provider doesn't accept the Member ID Card, it's often because they aren't familiar with our principles. The next step is to have them call Brotherhood's office using the phone number on the card. A brief conversation is usually all it takes to reassure them of our trustworthiness and resolve the issue.

    Step 3: Suggest the Provider Send You the Bill

    If the provider still won't accept you as a Brotherhood Member, suggest they send the bill directly to you. Do not pay the invoice. As soon as you receive it, send it immediately to Brotherhood. We will process it using our reference-based pricing, pay the fair price, and then invoice you for your Annual Unshared Amount (if any). Our prompt payment builds trust with the provider.

    Step 4: Pay at the Time of Service

    If the provider rejects the first three steps and requires immediate payment, we advise caution. Only agree if:

    - You are certain the price is fair and reasonable.
    - The bill is not over $1,000.

    It is quite common to pay at the time of service for primary care visits. If you do pay a bill at the time of service, be sure to send a copy of the paid receipt to Brotherhood. We will reimburse you if the eligible expenses exceed your Annual Unshared Amount

18. **How does Brotherhood establish fair and reasonable pricing?**
Brotherhood uses advanced software and medical pricing data to arrive at a fair and reasonable price. This approach is called reference-based pricing and includes various steps. First, the bill is evaluated and corrected for medical coding errors. Second, it is compared to industry benchmarks and adjusted to a fair and reasonable price based on medical pricing data. Third, the payment to providers contains a complete and clear explanation of the payment that provides true reasons behind a fair and reasonable price.

19. **How does Brotherhood negotiate unfair and exorbitant bills?**
After receiving a fair payment for medical services from the Plan, some providers will still demand payment for the remaining balance of the unfair and exorbitant bill. In this situation, a provider or hospital will invoice the Member for the unpaid balance. This is called balance billing. If you receive a balance bill, do not pay it. Send it to The Plan. Brotherhood engages in respectful bill resolution on behalf of its members. This includes interactive negotiation with providers to show medical pricing data and objective industry standards demonstrating the integrity of a fair and reasonable price.

20. **Does the plan share expenses for conditions that occurred prior to the Effective date?**
No. Exception: Members during a pregnancy, that join with 70% church participation, can share maternity expenses prior to the Effective date.

21. **What billing requirement does the Plan require from Providers and how do they submit it?**
Per the guidelines, bills must be submitted on Forms CMS-1500/HCFA or UB-04/CMS 1450 (or equivalent) for medical bill to be considered for sharing. If the provider has questions about billing, please contact The Plan.
    - Anabaptist Brotherhood, P.O. Box 144, Guys Mills, PA 16327
    - Email: info@AnabaptistBrotherhood.org
    - Phone: 574-354-4449

Six men with their teams plow the field for a brother in the church who was laid up with an injury.

Revisions to the Complete Guidelines

The following revisions were made to the 3rd edition of the Guidelines. These revisions are materially different than the previous edition of the Guidelines. If you are already a Member of The Plan, this page is a quick reference to update your understanding of the Guidelines. The outline numbering system of the Guidelines is used below to provide the location of each revision. "Addition" means that the guideline was added. "Deletion" means that the guideline was removed or eliminated.

III.A.1–5 **General Alms Plan Guidelines (**the following 5 points are additions)

1. **Individual Responsibility**

   Each person should carry their own financial burden as much as they are able.

2. **Church Responsibility**

   Each local church should help its members, bearing one another's burdens as much as they are able.

3. **Brotherhood's Role**

   After individuals and churches have done their part, the Alms Plan provides a larger umbrella, linking many churches together to share remaining financial alms needs.

III.A.14. **Priority for Participating Churches**

Addition: Alms requests from churches with 70% or greater participation are given priority over requests from churches with lower participation.

III.B., **Alms Plan**

Deletion: ~~Annual Alms contributions are due on the first day of November.~~

Addition: Quarterly Alms contributions are due on the first day of each quarter.

III.C.7.8. **Eligible Alms Expense**

Addition: **Annual Unshared Amount (AUA)** – If a medical incident is overwhelming for a household, the AUA can be paid by the Alms Plan.

Addition: **Quarterly Medical Contribution** – If the Quarterly Medical Contribution is overwhelming for a household, it can be paid by the Alms Plan.

Deletion: ~~Funerals~~

Deletion: ~~Long term nursing care~~

V.C.5. **Health Incentive Discount**

The Plan values healthy living and rewards Members who maintain good health. Members age 60 and older may qualify for a (Addition) 10% (Deletion: ~~5%~~) discount on their quarterly medical contribution by meeting certain health standards.

Eligibility Requirements

Addition: To qualify for the Health Incentive Discount, Members must meet all of the following requirements:

- Complete an annual primary care wellness visit
- Maintain a healthy weight (BMI < 30)
- Maintain a healthy blood pressure (≤ 130/80)
- Maintain a healthy blood sugar (A1C ≤ 6)
- Maintain healthy cholesterol levels (LDL ≤ 130 and HDL > 45)

VI.A.29. **Eligible for Sharing**

Diabetes and Kidney Treatments – Including dialysis

Addition: and other necessary care for Type 1 or Type 2 diabetes.

VI.B.2. **Ineligible for Sharing**

Major Procedures and Transplants

Addition: Heart, liver, and kidney transplants

VIII.A. **Motor Accidents**

Safety Equipment and Lifestyle

Expenses are not eligible for sharing if any of the following apply:

Deletion: ~~The minimum operator age recommended by the manufacturer or required by law was not followed. These apply regardless of whether the Member was operating the vehicle or was a passenger.~~

Addition: The activity involved a willful disregard for personal safety.

X.E.2. **Plan Details**

65 Years of Age and Older

Members on Medicare

Deletion: ~~Members 65 and older who are on Social Security and utilize Medicare A and B may stay on the Plan and receive a 50% discount of the Over 65 quarterly contribution amount.~~

Addition: Members 65 and older who are on Social Security and utilize Medicare receive discounts on the Over 65 quarterly contribution (see below) and are responsible for an AUA of $1,000 for an individual or $2,000 for a family.

Age and Status	Discount	Individual	Family
Over 65 (w/SSX)	–	$750	$1,500
Over 65 (w/SS) Medicare Part A	50%	$375	$750
Over 65 (w/SS) Medicare Parts A & B	60%	$300	$600
Over 65 (w/SS) Medicare Parts A, B & D	70%	$225	$450

X.I. **Plan Details**

Reapplication After Membership Cancellation

Former Members may reapply for membership.

Deletion: ~~Members who were cancelled by the Plan or choose to cancel on their own are welcome to reapply. If approved for membership, a reentry fee of $1,500 applies~~

Addition: Prior to approval, **the last unpaid** quarterly contribution and AUA (if any) must be paid.

X.K.7. **Eligibility for Sharing**

Addition: Occupational or Work-Related Injuries

- Expenses for self-employed individuals' work-related injuries or illnesses are eligible for sharing.
- W-2 employee injuries are not eligible. See Worker's Aid Plan for sharing work-related injuries for W-2 employees.

X.R. **Medical Reserve Funds**

Addition: Brotherhood's reserve funds are held in trust for the Members. If a church with 70% or greater participation withdraws from the organization, it will receive a prorated portion of the reserve funds.

- The prorated amount is determined case by case to ensure fairness based on participation level and contribution history.

Individuals from churches with less than 70% participation who withdraw from the organization do not receive a prorated portion of the reserves.

XI.F. **Office and Billing**

Addition: **Our Commitment to Privacy**

Anabaptist Brotherhood deeply values your privacy and is committed to protecting your personal health information (PHI). Although Brotherhood is not an insurance company and is therefore not legally subject to the federal Health Insurance Portability and Accountability Act (HIPAA), we voluntarily follow HIPAA–like privacy standards to safeguard your information. We use your information only for purposes related to membership, bill processing, and sharing. We do not sell or share your information for marketing or commercial use.

Member Application

Anabaptist Brotherhood
caring for our own

1. Household Demographics

Primary Household Member

First Name ____ *Initial* ____ *Last Name* ____ *DOB (MM/DD/YYYY)* ____ *Last 4 Digits of SSN* ____ Male Female *Gender (Circle)*

Are you Social Security exempt? *Yes* *No*   Marital status: ____

If you are covered by Medicare, please indicate: *Part A* *Part B* *Part C* *Part D*

Spouse

First Name ____ *Initial* ____ *Last Name* ____ *DOB (MM/DD/YYYY)* ____ *Last 4 Digits of SSN* ____ Male Female *Gender (Circle)*

Are you Social Security exempt? *Yes* *No*

If you are covered by Medicare, please indicate: *Part A* *Part B* *Part C* *Part D*

Children / Dependents *List children under age 19. Use a separate application for children 19 or older*

First Name ____ *Initial* ____ *Last Name* ____ *DOB (MM/DD/YYYY)* ____ *Last 4 Digits of SSN* ____ Male Female *Gender (Circle)*

First Name ____ *Initial* ____ *Last Name* ____ *DOB (MM/DD/YYYY)* ____ *Last 4 Digits of SSN* ____ Male Female *Gender (Circle)*

First Name ____ *Initial* ____ *Last Name* ____ *DOB (MM/DD/YYYY)* ____ *Last 4 Digits of SSN* ____ Male Female *Gender (Circle)*

First Name ____ *Initial* ____ *Last Name* ____ *DOB (MM/DD/YYYY)* ____ *Last 4 Digits of SSN* ____ Male Female *Gender (Circle)*

First Name ____ *Initial* ____ *Last Name* ____ *DOB (MM/DD/YYYY)* ____ *Last 4 Digits of SSN* ____ Male Female *Gender (Circle)*

First Name ____ *Initial* ____ *Last Name* ____ *DOB (MM/DD/YYYY)* ____ *Last 4 Digits of SSN* ____ Male Female *Gender (Circle)*

Household Address: ____ City ____ State ____ ZIP ____

Phone: ____ Email/Fax ____

Household Income Tier: (See section III.B. of the Complete Guidelines.) *(Circle one)*
$1–25,000 • $25,001–50,000 • $50,001–75,000 • $75,001–100,000 • $100,001–150,000 • $150,001–200,000 • $200,001 & above

Church Name: ____

Church Contact: ____

Phone: ____ Email/Fax ____

Contact Address: ____ City ____ State ____ ZIP ____

Effective start date — Indicates the 1st day of the month you wish to join: ____

Name of previous medical aid plan *(if any)*: ____ Annual cost: $____

Member Application

Anabaptist Brotherhood
caring for our own

2. Health History Questionnaire

Complete a questionnaire for each individual (including children under 19 years of age) applying for membership in this application. Make copies as needed.

Name: _____ Height: _____ Weight: _____

Pregnant? Yes No N/A Vaping or any tobacco use? Yes No

Past Medical History ○ No Past Medical History

1. Place a check mark to indicate all past or current medical history. Write in any other medical conditions not specifically identified. Provide comments as necessary for clarity.
2. Circle all the conditions with a historical or anticipated annual expense of $5,000 or more.

Cardiovascular & Circulation:
○ high blood pressure ○ heart failure ○ heart attack ○ atrial fibrillation/flutter
○ peripheral vascular disease ○ blood clots ○ heart valve disease ○ high cholesterol
○ other: _____

Respiratory:
○ asthma ○ chronic obstructive pulmonary disease ○ sleep apnea
○ pulmonary embolus ○ other: _____

Neurological:
○ dementia ○ Parkinson's disease ○ seizure disorder ○ stroke/mini stroke
○ other: _____

Musculoskeletal:
○ arthritis ○ osteoporosis ○ other: _____

Endocrine/Metabolic:
○ diabetes type 1 ○ diabetes type 2 ○ hypothyroid ○ hyperthyroid
○ other: _____

Gastrointestinal:
○ Crohn's disease ○ acid reflux ○ ulcerative colitis ○ liver disease
○ other: _____

Eye/Ear:
○ cataracts ○ glaucoma ○ macular degeneration ○ other: _____

Urinary/Kidney:
○ kidney failure ○ dialysis ○ kidney stones ○ other: _____

Cancers:
○ leukemia ○ melanoma ○ lymphoma ○ other: _____

Blood:
○ anemia ○ hemophilia ○ sickle cell ○ other: _____

Mental Health:
○ bipolar ○ depression ○ anxiety ○ other: _____

Autoimmune:
○ lupus ○ other: _____

Past Surgical History *List any previous surgeries.* ○ No Past Surgical History

_____

_____

Current Medications: *List all current prescription and over-the-counter medications including dose and frequency.* ○ No Medications

_____

_____

_____

_____

Member Application

Anabaptist Brotherhood
caring for our own

3. Acknowledgments and Authorization

Adults 18 years and older must sign and complete this form.

- I agree to comply with the Medical Aid & Alms Plan Complete Guidelines. I acknowledge that I have an adequate understanding of the Plan and its limitations, and that my participation is strictly voluntary. I understand that the plan will be active on the effective date listed in my application confirmation letter.
- I certify that the information provided in this application is true, accurate, and complete to the best of my knowledge.
- I understand that Anabaptist Brotherhood Medical Aid & Alms Plan is not insurance and should never be construed as a contract for health insurance. I hold ultimate responsibility and am legally liable for the payment of my own medical bills. Brotherhood offers no legal guarantee and shall not be legally liable for the payment of my medical bills. Further, I understand that no Member shall be forced or compelled to make sharing contributions. Contributions from Members are voluntary gifts and are non-refundable. If sharing occurs, the shared medical expenses are paid solely from voluntary contributions of Members. Brotherhood serves to facilitate this mutual sharing by managing the Members' pooled funds for those who have eligible expenses.
- I authorize Anabaptist Brotherhood to use and disclose my medical information for purposes of cost sharing, case management, and general organizational use. I grant permission to negotiate and pay bills on my behalf. I authorize Brotherhood to discuss any medical bills with my church's contact person. Any information shared will be limited to what's necessary to support the coordination of my medical care and the sharing of eligible expenses within the ministry.

_____ _____

Signature of Head of Household *Signature of Spouse*

_____ _____

Signature of Adults 18 years and older *Signature of Adults 18 years and older*

_____

Printed Name of Head of Household

Mail, email, or fax completed application to:

P.O. Box 144, Guys Mills, PA 16327

info@anabaptistbrotherhood.org

814-529-0068

Fax: 814-529-0068

(This page intentionally left blank.)

The 10 Differentiators that Make Anabaptist Brotherhood Unique

1. **Medical Aid is combined with Alms Aid.** For mutual aid to truly work without reliance on government programs, medical aid and alms aid must be linked together and shared across a network of churches. This is the old way of doing mutual aid, and it remains the best path for the future. Members share each other's expenses, without sacrificing their conscience along the way. Anabaptist theology has deep roots by the rivers of mutual aid that brings forth the fruit of being one's brother's keeper. Like a tree by these waters, Brotherhood's roots go deep and draw upon old Anabaptist theology of bearing each other's burdens. The key practice includes tying medical aid and alms closely together—combining financial aid for medical, people with disabilities, widows, and low income into one seamless Plan.

2. **Fair and Reasonable Pricing**. *The Plan* facilitates the difficult work of processing and paying a fair price for medical services and treatments. With the complexity and lack of transparency of the medical system's billing approach, it is nearly impossible for the average individual to know the fair price of medical bills. As a result, too many medical sharing plans are overpaying for medical services and treatments. The time is ripe to address this escalating problem!

   Brotherhood utilizes an approach called reference-based pricing. It compares medical pricing data to industry benchmarks to arrive at a fair price. We do not use or accept large discounts from hospitals or providers as a basis for fair pricing because it is too misleading and lacks transparency. In many cases, these large discounts deceptively leave the patient feeling like they got a real deal. Is it really a savings? One thing for sure, big discounts are at the heart of the medical system's lack of pricing transparency. By simply accepting discounted medical bills, we exacerbate the problem.

3. **Negotiating exorbitant and excessive bills**. After receiving a fair payment from the Plan, some providers will still demand payment for the unpaid portion of an unfair and exorbitant bill and invoice the patient or member for the remaining balance. This is called balance billing. When this occurs, Brotherhood engages in respectful bill resolution on behalf of its members. This includes interactive negotiation with providers to show medical pricing data, analytics, and industry standards, thereby demonstrating the integrity of a fair and reasonable price.

4. **Direct Billing and Payment.** The Plan facilitates medical bills on behalf of the members by requiring medical providers and facilities to send the bill directly to the Plan. After processing and negotiating the bill, the Plan makes payment directly back to the providers and facilities using the shared funds provided by the Members' contributions. This streamlines the bill payment process and alleviates the stress and confusion of Members paying the bill directly to providers.

5. **Preexisting Conditions.** Preexisting conditions are accepted without an annual expense cap or limit for applicants from churches with 70% or greater member participation. By comparison, preexisting conditions are accepted with an annual expense cap of $10,000 for applicants from a church with less than 70% member participation.

6. **Preferred Providers and Treatments.** The Plan publishes an annual booklet with info and pathways to preferred hospitals, providers, and clinics that offer reasonably priced services and quality treatments, prescription medications, and therapies. This *Preferred Providers and Treatments* booklet does not limit the Members' choice of where to get treatments but informs them of wise options.

7. **Discernment about Alternative Healthcare.** The Plan employs a Therapeutics Evaluation Committee of medical experts to evaluate and analyze treatment and services. This includes alternative, functional, and natural providers and treatments. If deemed eligible, the treatments and therapies are annually published in the *Preferred Providers and Treatments* booklet and approved for sharing.

8. **Health Education.** Health education is a golden thread in Brotherhood's economic fabric. While our upfront mission is helping each other share medical expenses, our foundational mission is to help people learn how to live healthy lives and learn to navigate a medical system that is fixated on sickness rather than health. We offer every Member a free subscription to the *Our Health* magazine and other health educational materials. The ultimate solution to affordable healthcare is to live disciplined, healthy lives!

9. **A Comprehensive Plan.** From prenatal care to death, Brotherhood's plan is a comprehensive sharing plan for a wide range of medical services. For example, the Plan includes Primary Care (family doctor visits) for sick visits and wellness checkups as well as Telehealth. It also includes Preventive Care. For a complete list of eligible and ineligible expenses, request a copy of the Complete Guidelines. The guidelines provide detailed descriptions to easily understand the scope of eligible and ineligible medical conditions and treatments.

10. **Social Security Exemption.** With the above nine differentiators, the Plan solves the long-standing problems among the Anabaptists associated with the Form 4029 Social Security Exemption. It provides a sustainable economic path for those that choose to be Social Security Exempt. More importantly, the Plan provides a strong economic solution for both exempt and non-exempt members and resolves the tensions and uncertainty that many churches feel regarding Social Security issues.

Board of Directors

- **Thomas Mast** | Chairman
  Nappanee, IN – Beachy Fellowship
- **Jonathan Lehman** | Vice Chairman
  Fredericksburg, PA – Hope Mennonite Fellowship
- **Mark Martin** | Treasurer
  Lititz, PA – Weaverland Conference
- **Loren Strickler** | Secretary
  Annville, PA – Pilgrim Conference
- **Ivan Hochstetler** | Board Member
  Millersburg, OH – Amish
- **Merle Herr** | Administrator
  Guys Mills, PA – Meadville Mennonite Church

Contact Information

Anabaptist Brotherhood
P.O. Box 144, Guys Mills, PA 16327

Phone: 574-354-4449
Fax: 814-529-0068
Email: info@AnabaptistBrotherhood.org
Website: AnabaptistBrotherhood.org

Anabaptist Brotherhood is 501 (c) (3) approved.

3rd Edition 10-1-2025