

SHARERIGHT

A PROGRAM OF IMPACT HEALTH SHARING

Member Guidelines

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About ShareRight

ShareRight is a program of Impact Health Sharing. Impact Health Sharing was created to facilitate the sharing of medical bills and expenses among Members.

SHARERIGHT IS NOT AN INSURANCE COMPANY. IMPACT HEALTH SHARING IS NOT AN INSURANCE COMPANY. HEALTH SHARING IS NOT INSURANCE OR A CONTRACT FOR INSURANCE. THE PAYMENT OF MEDICAL BILLS THROUGH SHARERIGHT, IMPACT HEALTH SHARING, OR OTHERWISE IS NOT GUARANTEED IN ANY WAY.

ShareRight and Impact Health Sharing are not insurance, and these Sharing Guidelines are not a contract for insurance. Neither ShareRight nor Impact Health Sharing is liable for the payment of a Member's medical bill. There is no transfer of risk from a Member to ShareRight or Impact Health Sharing.

Statement of Shared Beliefs & Ethics



ShareRight is a program of Impact Health Sharing, a not-for-profit corporation that exists to create, exercise, and express practical applications of Christian faith, beliefs, and ethics. ShareRight operates in alignment with Impact Health Sharing's belief in bringing together individuals and families in shared acts of common good.

We believe that the expression of these things, and the right to associate in the exercise of their expression, is a fundamental right guaranteed under the United States Constitution.

We welcome all people who are willing to honor and abide by Impact Health Sharing's Statement of Shared Beliefs & Ethics, by which ShareRight operates. We are a community that shares a common belief that by coming together, sharing together and acting together, we provide greater opportunities for health and freedom to our neighbors and, in turn, we gain the same opportunities for ourselves and our families.

As a community, we believe that it is both true and self-evident that all persons are created equal and in the likeness of God. We believe that all persons have been endowed, by God, with unalienable rights such as life, liberty, and the pursuit of happiness, and that these rights should be available to all.

As families and individuals, we believe we share the responsibility of ensuring that the pursuit of life, liberty, and happiness is available to all.

As a community, we share a belief that contributing to one another's medical bills expresses our commitment to help each other pursue a life of liberty and happiness. At the core of what we do, and how we relate to and engage with one another as a community of people, is a set of common beliefs.

ShareRight is a program of Impact Health Sharing and operates in alignment with Impact Health Sharing's Statement of Shared Beliefs & Ethics, which is as follows:

1. We believe that our rights and liberties originate from God and are bestowed by God.
2. We believe that everyone is created equal and in the likeness of God.
3. We believe that all persons have the right to life, liberty, and the pursuit of happiness.

4. We believe in the principle taught by Christ of "love thy neighbor as thy self," regardless of race, religion, or creed.
5. We believe we have a moral and ethical obligation taught by Christ to assist others in need.
6. We believe that the Christian ideal of sharing and contributing to each other's medical bills is an expression of our commitment to our obligations to one another as a Christian-based community.
7. We believe that it is our ethical duty to one another to maintain a healthy lifestyle and avoid foods, behaviors, habits, or any choices and activities that produce sickness or disease to ourselves or others.
8. We believe that we have an ethical duty to each other to make legal, mature, and responsible decisions that do not create a risk of injury to ourselves or others.
9. We believe it is our fundamental right of conscience to direct our own healthcare in consultation with our physicians, family, or other valued advisors.
10. We believe we have a fundamental right guaranteed under the United States Constitution to associate in the lawful exercise of our common belief to voluntarily share health care expenses with one another.

ShareRight Statement of Faith

ShareRight is a program for those who, in addition to honoring Impact Health Sharing's Statement of Shared Beliefs & Ethics, share a common Christian faith. As ShareRight Members:

1. We believe Jesus Christ is the Son of God, and salvation is offered through His death and resurrection.
2. We believe the Bible is inspired by God and is our guide for life.
3. We believe in the power of prayer, and we commit to praying for one another.

To become and remain a ShareRight Member, each applicant must agree with both Impact Health Sharing's Statement of Shared Beliefs & Ethics and the ShareRight Statement of Faith.





I. Bill Sharing

A. Healthcare Sharing is Voluntary

In short

How is ShareRight's voluntary sharing different from insurance?

ShareRight members choose to share one another's medical bills, as acts of common good in keeping with our shared beliefs. Because that money belongs to the members, we share requests that fall within these Guidelines and don't share those that fall outside them. ShareRight isn't insurance.

A community that shares by choice

Healthcare sharing is a voluntary sharing arrangement that brings together individuals and families in the ShareRight community in voluntary acts of common good, consistent with the Impact community's Statement of Shared Beliefs & Ethics and the ShareRight Statement of Faith.

Not insurance

ShareRight and Impact Health Sharing are not insurance, and these Sharing Guidelines are not a contract for insurance.

Good stewards of members' money

The money used to pay Sharing Requests belongs to the collective membership—not to ShareRight or Impact Health Sharing. That's why we must be good stewards of it: we approve Sharing Requests that fall within these Guidelines, and we don't approve those that fall outside them.

Want to see how it works? Watch this short video **[link to come]**. You can also call our member services team.

B. Eligible for Sharing

In short

Which medical bills are eligible for sharing?

Medical bills for a new condition, injury, or illness can be shared, subject to your Primary Responsibility Amount (PRA) and co-share (if applicable). Some bills have limits or aren't eligible, and we can tell whether a bill is eligible only after you receive care and the bill is submitted. We need to receive bills within 12 months of the date of service.

What can be shared

Medical bills related to a new condition, injury, or illness are eligible for sharing, as long as they aren't listed in Section I. D. Not Eligible for Sharing. These bills may be subject to limitations if they're listed in Sections I. C. Limited Sharing.

Your PRA and co-share

Bills eligible for sharing are subject to your Primary Responsibility Amount (PRA) and co-share (if applicable), and to the other limitations and exclusions in these Guidelines.

When we can tell you if a bill is eligible

We can't determine eligibility for sharing until after you receive medical services and the bills are submitted for sharing.

Deadline to submit

We must receive bills within 12 months of the date of service for them to be considered for sharing.

Here's how that works

Say you have an urgent care visit on March 3, 2027. For that bill to be considered for sharing, we need to receive it within 12 months of March 3, 2027. A bill that reaches us after that won't be considered.

How bills are submitted

Bills need to come from your provider, following standard healthcare industry submission and coding guidelines, to be considered for sharing.

Submitting a bill yourself

If you need to submit a bill yourself, submit it electronically using the bill submission tool in the Member Center. You're responsible for gathering and providing all required information, because we accept only complete submissions for review and processing. You're also responsible for any costs of obtaining necessary records or documentation.



Need help submitting a bill? Watch the step-by-step video, How to Submit a Medical Bill, to learn the specific requirements. You can also call our member services team.

C. Limited Sharing

In short

Which bills fall under Limited Sharing?

Limited Sharing describes the kinds of care that can be shared within set limits, such as a dollar cap, a visit limit, or a waiting period. Each category below explains its limits. Your PRA and co-share (if applicable) still apply unless a category says otherwise.

The following medical bills for certain conditions may be eligible for sharing, subject to your PRA and co-share (if applicable) and other conditions that may apply. See each category below for details.

1. Maternity

In short

Is my pregnancy eligible for sharing?

Maternity expenses can be shared, up to $150,000 per baby (for example, $300,000 for twins), when the mother is a member and her documented due date is at least 10 months after her membership start date. Your newborn can join from the date of birth if you submit the request in time.

Who's eligible

Maternity expenses are eligible for sharing if the mother is a member and her Estimated Due Date (EDD), as documented in the medical record, is at least 10 months after her membership start date. The documented EDD determines eligibility, regardless of the actual birth date, because some births happen before or after the estimated date.

Here's how that works

Say your membership starts January 1, 2027, and your documented EDD is December 1, 2027. That's more than 10 months later, so your maternity expenses are eligible, even if your baby arrives early. If your documented EDD were September 15, 2027, less than 10 months after your start date, they wouldn't be.

Sharing limit

Sharing is limited to $150,000 per baby for any pregnancy event (for example, $300,000 for twins), including antepartum care, the cost of delivery, complications to the mother and/or child(ren), and postpartum care. The baby's bills are part of the pregnancy event, including admissions within 72 hours of birth, until the baby's final discharge home, as long as the baby is added to the membership within 30 days of birth (see "Adding your newborn" below).



One global bill

Maternity care is usually billed as one global bill that includes prenatal visits, delivery, and postpartum care. That's why only one global maternity bill per pregnancy is eligible for sharing. If care begins with a midwife and later transfers to a physician, sharing applies to the one provider who submits the global bill.

Conditions found before joining

For ineligible maternity events, any fetal abnormalities and/or congenital abnormalities noted in medical records before the mother joined ShareRight are considered a pre-existing condition and aren't eligible for sharing.

Who can deliver

To be eligible, delivery must be performed by a Medical Doctor, Doctor of Osteopathy, Nurse Practitioner, Physician's Assistant, or Midwife who is properly licensed, certified and/or registered in the state of delivery.

Adding your newborn

Your newborn can be a member starting on the date of birth, as long as you submit the request within 30 days of the date of birth. Requests to add newborns to membership can't be backdated more than 30 days.

Want to know more? Watch this short video about maternity sharing. You can also call our member services team.

2. Prescriptions

In short

Will ShareRight help with my prescriptions?

What you pay for prescriptions can count toward your annual PRA. Once your PRA is met, eligible prescriptions can be shared after the first $25 per fill for a generic or $50 per fill for a brand-name drug, up to $1,200 per member per membership year.

What counts toward your PRA

Prescription medication expenses for prescribed drugs that may be dispensed, injected, or administered may be credited toward your annual PRA if they aren't considered treatment for a pre-existing condition.

You pay 100% of the prescription amount at the pharmacy and submit eligible expenses in the Member Center. Only the amount you pay over $25 per fill for generic and over $50 per fill for brand-name medications is applied to your annual PRA.

After your PRA is met

After your annual PRA is met, eligible prescriptions are shared as follows:

- After the first $25 on generic drug prescription
- After the first $50 on brand-name prescription when a generic is unavailable

The shareable amount is limited to $1,200 per member, per membership year after your annual PRA is met.

Here's how that works

Say you fill a generic prescription that costs $40. You pay the $40 at the pharmacy and submit it in the Member Center. Before your PRA is met, the $15 above the first $25 counts toward your annual PRA. After your PRA is met, that $15 is eligible for sharing, up to the $1,200 yearly limit.

Good to know

- Exceptions may be made for medications for cancer and transplant recipients.
- You must purchase prescription medications using your member ID card (see the Rx information on the card).
- Psychotropic medication and birth control expenses aren't eligible for sharing.
- Members 65 and older must have Medicare Part D for prescription costs to be eligible for sharing. All sharing is secondary to Medicare.

Want to know more? Watch this short video about prescriptions. You can also call our member services team.

3. Preventive Screening

In short

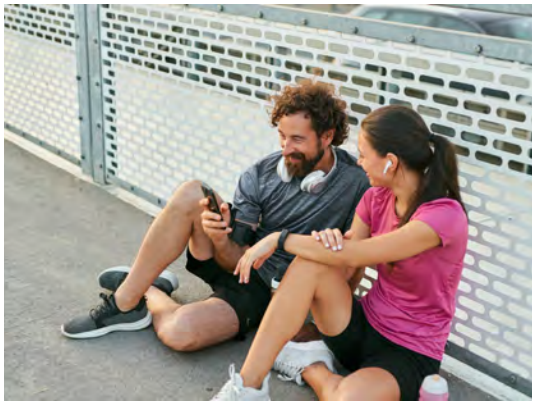
Which screenings are eligible for sharing?

The screenings below can be shared on the schedule listed, subject to your PRA and co-share (if applicable). Screenings outside the schedule can be shared when they're medically necessary and not related to a pre-existing condition.

Preventive screening, as outlined below, is subject to your PRA and co-share (if applicable).

- Women: Pap test—one every three years from age 21–65
- Mammogram—one every year for ages 40–74
- Men: PSA test—one every year, starting at age 45
- All: Colonoscopy—one every 10 years starting at age 45 or one every five years for members at high risk

For eligible preventive care, both the test and the coordinated office visit are eligible for sharing.



Here's how that works

Say you had a colonoscopy at 46 and you're not at high risk. Your next routine colonoscopy can be shared at 56. If you need one sooner and it's medically necessary and not related to a pre-existing condition, it can still be shared (see Good to know).

Good to know

- Exceptions are made for testing outside the timelines above when it's determined to be medically necessary and not related to a pre-existing condition.
- We process bills in the order we receive them to apply allowances and sharing. For example, the $150 wellness lab allowance (see Section I.C.13) applies to a Pap test or PSA test only if we receive that bill before the bill for your routine labs. Otherwise, it applies to the routine labs.

4. Mental Health

In short

Is counseling or therapy eligible for sharing?

Mental health sharing is limited to two kinds of care. Virtual short-term teletherapy is shared only through the approved teletherapy provider: up to three visits a month are complimentary, and you pay upfront for more and submit them for sharing. Outpatient mental health care is limited to five visits per member each membership year, subject to your PRA and co-share (if applicable).

Virtual short-term teletherapy

Virtual Short-Term Teletherapy is eligible for sharing only when you use the approved teletherapy provider (found in the Member Center).

Your membership includes up to three complimentary short-term visits per month, and the provider fee for Virtual Short-Term Teletherapy is waived. For additional visits beyond that, you pay 100% upfront and submit those expenses to be considered for sharing.

To learn more about this member perk, visit the virtual care page.

Outpatient mental health care

Outpatient Mental Health Care is eligible for sharing, up to five visits per member, per membership year, when performed by a qualified provider. Outpatient Mental Health providers are considered Specialists for provider fee purposes, and these visits are subject to your annual PRA and co-share (if applicable).

5. Outpatient Therapy

In short

How many therapy visits are eligible for sharing?

Up to 50 outpatient therapy visits per member, per membership year, can be shared for the therapies listed below, subject to your PRA and co-share (if applicable). The 50 visits are a total for all listed therapies, not 50 of each.

Outpatient therapy that isn't related to a pre-existing condition is limited to 50 visits per member, per membership year, regardless of the type of outpatient therapy, as long as the therapy is included in the list below. These visits are subject to your annual PRA and co-share (if applicable).

- Chiropractic Adjustment (X-rays and manipulations)
- Physical Therapy
- Vision Therapy
- Occupational Therapy
- Speech Therapy
- Respiratory Therapy
- Cardiac Rehabilitation



Here's how that works

Say you have 30 physical therapy visits and 20 chiropractic adjustments in one membership year. That's 50 visits, so more outpatient therapy that year isn't eligible for sharing, even a different type.

Want to know more? Watch this short video about outpatient therapy. You can also call our member services team.

6. Cancer

In short

Is there a waiting period if my cancer is in remission?

Cancer in complete remission has a 36-month waiting period. Surveillance testing isn't shared for your first 36 months of membership. After 36 months without signs, symptoms, testing (other than surveillance), diagnosis, or treatment, bills for that cancer become eligible for sharing.

If you've been diagnosed with cancer that is in complete remission and you're only having testing for surveillance purposes, bills for those services won't be eligible for sharing for your first 36 months of membership. After 36 months without signs, symptoms, testing (other than surveillance testing), diagnosis, or treatment (medication), medical expenses related to that cancer diagnosis will be eligible for sharing.

7. Durable Medical Equipment

In short

Is equipment like a wheelchair or walker eligible for sharing?

Durable medical equipment for an eligible need is limited to $500 per member each membership year, toward rental or purchase. Before your PRA is met, it counts toward your PRA; after, it's shared, subject to co-share (if applicable).

Durable Medical Equipment (DME) is any equipment that provides therapeutic benefits to a patient in need because of certain medical conditions and/or illnesses, can withstand repeated use, is appropriate for use in the home, and is ordered or prescribed by a physician for a condition.

DME related to an eligible need is eligible for sharing, up to $500 per member per membership year toward the rental or purchase, once your PRA is met. DME expenses are also subject to your PRA and co-share (if applicable).

Here's how that works

Say your doctor prescribes a knee scooter after surgery, and it costs $650 to buy. If you haven't met your PRA yet, up to $500 of it counts toward your PRA. If you've already met your PRA, up to $500 is eligible for sharing that membership year, subject to co-share (if applicable). Either way, the other $150 is yours.

8. Prostheses

In short

Are prostheses eligible for sharing?

Yes, as long as the prosthesis isn't for a pre-existing condition. Up to two in your lifetime for the same condition are eligible.

Lifetime limit

Prostheses not related to a pre-existing condition are eligible for sharing, up to two per lifetime for the same condition, once your PRA is met. They're also subject to co-share (if applicable).

9. Motor Vehicle Accidents

In short

Are injuries from a car accident eligible for sharing?

Vehicle insurance pays first. After that, injuries from a motor vehicle accident can be shared, as long as all required and recommended safety equipment was in use. Motorcycle accidents are limited to $100,000 per incident. Treatment isn't shared if alcohol or legal drugs were abused or federally illegal drugs were used.

Vehicle insurance and safety equipment

Sharing is secondary to the vehicle insurance. Treatment related to injuries received while in a motor vehicle is eligible for sharing, as long as all legally required and industry-recommended safety equipment was in use. Treatment related to motorcycle accidents is limited to $100,000 per incident once your PRA is met, subject to co-share (if applicable).

When treatment isn't shared

Treatment isn't shared if there was abuse of alcohol or legal drugs or the use of federally illegal drugs.

Here's how that works

Say you're wearing your seat belt when another car hits yours, and the vehicle insurance only pays part of your hospital bill. The remaining eligible amount can then be considered for sharing, subject to your PRA and co-share (if applicable).

10. Tobacco Users

In short

What if I'm a tobacco user?

If you use tobacco or vape regularly, you pay a $50 monthly Tobacco Assessment (except in the Senior 65+ program). For tobacco users 50 and older, sharing for stroke, cancer, heart conditions, and COPD is limited to $50,000 per lifetime for each.

Lifetime limits for tobacco users 50 and older

Medical cost sharing for the needs of tobacco users 50 and older is limited to $50,000 per lifetime for each of the following four disease categories:

- Stroke
- Cancer
- Heart conditions
- Chronic obstructive pulmonary disease (COPD)

Here's how that works

Say you're 55 and use tobacco, and over several years you have $70,000 in eligible bills for a heart condition. Up to $50,000 of those can be shared. A separate cancer diagnosis would have its own $50,000 limit.

Tobacco Assessment

If you use tobacco or vape regularly, you're required to pay a Tobacco Assessment of $50 per month. The Tobacco Assessment doesn't apply to the Senior (65+) program.

We'll let you know during the application process, before you join, if the Tobacco Assessment applies to you.

If you don't disclose tobacco use and we learn of it after your membership start date, your membership may be terminated.

11. Medical Transportation

In short

If I need an ambulance, is that eligible for sharing?

Ambulance transport to the nearest facility can be shared only in a medical emergency or when it's medically necessary to move you for admission to another facility. Air ambulance is limited to $25,000 per member per lifetime. Rides to appointments aren't shared.

When transport can be shared

Medical transportation to the nearest facility, including ground and air ambulance services to hospitals, is eligible for sharing in a medical emergency (as defined in the Glossary of Terms) or when it's medically necessary to transport you for admission to another medical facility.



Limits

Air ambulance is limited to $25,000 per member per lifetime. Transportation to appointments isn't eligible for sharing.

12. Home Health

In short

Are home visits from a nurse eligible for sharing?

Up to 40 home nurse visits per membership year can be shared for eligible needs, no matter how many needs you have. Each visit is eligible for sharing for up to four hours.

Visit limits

Skilled care at home services for an eligible need are limited to 40 visits per member per membership year by a registered ARNP, LPN, or RN. Each visit is limited to a maximum block of four hours and is subject to your PRA and co-share (if applicable).

13. Wellness

In short

Is my yearly checkup eligible for sharing?

Yes. Members 6 and older get one wellness visit each membership year, plus up to $150 for the labs listed below, shared at 100% with no PRA or co-share. Children under 6 get one visit at 100%; their other well-child visits are subject to your PRA and co-share (if applicable).

Shared at 100%

Wellness Visits and Diagnostic tests are eligible for sharing as follows. Both the annual/well office visit and the $150 lab allowance are shared at 100% and aren't subject to the PRA or co-share.

Members 6 and older

Members 6 and older get one annual/well office visit per membership year, which includes a $150 allowance toward any of the labs listed below. Lab costs above the $150 allowance are subject to your PRA and co-share (if applicable).

- Complete Blood Count with Differential and Platelets
- Comprehensive Metabolic Panel
- Lipid Profile with Lipoprotein Particle Assessment
- Hemoglobin A1C
- Vitamin D-25 OH
- C-Reactive Protein
- Fecal Occult Blood Test
- Pap Smear
- PSA



Here's how that works

Say you're 40 and have your annual wellness visit, with a lipid profile and hemoglobin A1C test that cost $120 together. The visit is shared at 100%, and the labs fall within the $150 allowance, so they're shared at 100% too.

Members under 6

Members under 6 receive one annual visit shared at 100%. Additional visits follow routine well-child guidelines set by the American Academy of Pediatrics and are subject to your PRA and co-share (if applicable).

Well-child care is defined as recommended routine check-ups and associated lab work, excluding vaccinations and/or immunizations.

Want to know more? Watch this short video about wellness. You can also call our member services team.

14. Virtual Care: Telehealth

In short

Can I see a doctor online?

Yes. Telehealth visits are complimentary when you use the approved telehealth provider and set up the visit through the Member Center.

How to use telehealth

Virtual telehealth visits are complimentary for members when conducted using the approved telehealth provider (found in the Member Center). The provider fee is waived at the time of service. Only telehealth visits initiated through the Member Center are eligible for sharing.

Telehealth is voluntary, too

Telehealth is subject to all other limitations of health sharing costs and is not a promise to pay or provide that service by ShareRight, Impact Health Sharing, or the membership. As with all other medical costs and expenses, contribution to Telehealth remains voluntary.

15. Sharing for Seniors

In short

What if I'm 65 or older?

You'll need Medicare Parts A and B, and Medicare pays first. After that, eligible bills are shared once your $1,000 PRA is met, with no co-share, and pre-existing condition limits don't apply. Prescriptions need Medicare Part D to be eligible, and Medicare Advantage (Part C) plans don't qualify.

Medicare comes first

Members 65 or older must have Medicare Parts A and B to participate in and maintain ShareRight membership. Sharing is secondary to Medicare and is based on the difference between the Medicare-allowable charges and the actual amounts paid by Medicare.

You must submit a copy of the Medicare Summary Notice/ Explanation of Benefits (EOB) and the CMS 1500, or UB and IB form.



Here's how that works

Say you're 68 and Medicare allows $1,000 for a procedure but pays $800. The $200 difference counts toward your $1,000 PRA. Once your PRA is met, amounts like this are shared with no co-share.

What's different at 65 and older

Members 65 and older have a $1,000 PRA. Eligible medical bills for members 65 or older are eligible for sharing with no co-share amount. The Pre-Existing Medical Condition limitations don't apply to members 65 and older. The Tobacco Assessment and BMI Assessment don't apply to the Senior (65+) program.

Prescriptions

Members 65 and older must have Medicare Part D for prescription costs to be eligible for sharing.

Not eligible for sharing

- Treatment for members age 65 or older that is not Medicare-eligible
- Treatment for members age 65 or older who are not enrolled in Medicare
- Medicare Advantage plans and/or Medicare Part C don't qualify for ShareRight's Senior Program.

16. Hospice

In short

Is hospice care eligible for sharing?

Yes, once your PRA is met, up to $15,000 over your lifetime, when a physician prescribes it and it isn't for a pre-existing condition. Co-share (if applicable) also applies.

Lifetime limit

Hospice care services not related to a pre-existing condition are eligible for sharing when prescribed by a physician. They're subject to a lifetime limit of $15,000 per member once your PRA is met, and are subject to co-share (if applicable).

17. Non-hospital Inpatient Admissions

In short

Is a stay at a rehab or skilled nursing facility eligible for sharing?

It can be, up to $15,000 per incident and subject to your PRA and co-share (if applicable), when it's medically necessary for an eligible condition and replaces care you'd otherwise need in a hospital. Drug and alcohol treatment facilities aren't included.

Which stays are eligible

Inpatient admissions to a skilled nursing facility, physical rehabilitation facility, or long-term acute care facility (excluding drug or alcohol treatment/rehabilitation facilities) may be eligible for sharing when they're deemed medically necessary and prescribed by a qualified provider for an eligible condition. The care must be intended to deliver services that would otherwise require an acute care setting.

Limit

Sharing is limited to $15,000 per incident and is subject to your PRA and co-share (if applicable).

18. Perimenopause and Menopause

In short

Is treatment for menopause eligible for sharing?

Yes, but only FDA-approved treatments prescribed for your documented diagnosis of perimenopause or menopause. These aren't considered pre-existing conditions.

What's eligible

Perimenopause and menopause aren't considered pre-existing conditions. Sharing is restricted to treatments, medications, procedures, and therapies that are FDA-approved for the treatment or management of perimenopause and/or menopause and prescribed for an FDA-approved indication consistent with your documented diagnosis (Menopause or Perimenopause).

Not eligible for sharing

- Off-label uses
- Compounded medications
- Bioidentical hormone formulations not FDA-approved for the diagnosed condition
- Investigational or experimental therapies
- Wellness, anti-aging, optimization, preventative, or elective treatments
- Any treatment not expressly approved by the FDA for the applicable diagnosis

D. Not Eligible for Sharing

In short

What isn't eligible for sharing?

Some care isn't eligible for sharing at all. That includes care tied to illegal activity or drug use, care that isn't medically necessary or proven, certain kinds of care (such as inpatient mental health, fertility treatment, and weight management), over-the-counter items and some medications, and complications from anything on this list.

Medical bills related to the following conditions aren't eligible for sharing:

Illegal activity and drug use

- Treatment that is in violation of the Statement of Shared Beliefs & Ethics, including illness or injury arising from grossly negligent acts, use of illegal drugs, abuse of alcohol, or any illegal activity, whether or not an arrest is made, charges are filed, or a conviction results
- Treatment related to current use of illegal drugs

Care that isn't medically necessary or proven

- Procedure or surgery that is not medically necessary
- Prophylactic (treatment intended to prevent disease) and preventive surgery without a personal history of diagnosis and a doctor's recommendation
- Voluntary procedures/treatment, including cosmetic surgery or gender-affirming (transgender-related) surgery
- Alternative or naturopathic treatment
- Experimental treatment
- Treatments, procedures, and medications that are not FDA and CMS approved
- Genetic testing not required for treatment of an existing condition
- Sleep studies not related to a specific disease or disorder

Kinds of care

- Drug/alcohol treatment or rehabilitation that is residential (inpatient) or outpatient
- Inpatient mental health services
- Nutrition services
- Fertility/infertility treatment
- Weight management treatment or procedures
- Treatment related to genetic defects, hereditary diseases, or congenital conditions present before membership
- Routine or preventive care not listed in the "Preventive Screening" or "Wellness" sections above
- Dental or vision services not related to a medical injury or illness
- Vaccinations and/or immunizations

- Direct Primary Care costs
- Transportation to appointments

Medications, supplies, and devices

- Non-prescription (over-the-counter) drugs and medical supplies/equipment
- Psychotropic medication
- Birth control
- Medical marijuana
- Hearing aids
- Orthotics

Members 65 and older

- Treatment for members aged 65 or older that is not Medicare-eligible

Complications

- Complications related to ineligible procedures, conditions, and diagnoses. This includes any related future needs.

Here's how that works

Say you have cosmetic surgery and later develop an infection from it. The surgery isn't eligible, and neither is treatment for the infection, because it's a complication of an ineligible procedure.

Good to know

Dental and vision care related to a medical injury or illness, and the screenings and wellness care listed in C.3 and C.13, can still be eligible for sharing.

E. Discretionary Review of Sharing Requests

In short

What happens if it is not clear whether my bill is eligible for sharing?

When it isn't clear whether your bill is eligible for sharing, we use judgment, common sense, and fairness, and we may ask for medical records. A request can be denied, and membership canceled, if information is hidden or falsified or a member is abusive to staff.

When a request isn't clear-cut

We evaluate each Sharing Request under these Guidelines. At times, whether a request is valid may be unclear. In these situations, we must exercise discretionary judgment, on behalf of the entire membership, to evaluate the request, using common sense and fairness as a guide. We may also need medical records to help determine if sharing is eligible.

When a request may be denied

We're likely to deny a Sharing Request, and may cancel membership, if any of the following occur:

- Pre-existing conditions were not disclosed during the application process
- Relevant information appears to be obfuscated or changed during the sharing request process
- A member is abusive to Impact staff during the processing of a sharing request
- Failure to obtain requested medical records, fraudulent misrepresentation of, and/or purposely withholding certain portions of medical records
- Intentional violation of the guidelines, as determined by Impact, indicating that intent was apparently not accidental

Your part

You're expected to fully cooperate with us in evaluating Sharing Requests, including getting medical records. You're responsible for any costs of obtaining necessary records or documentation.

Falsified documents

Any Member who submits falsified documents or otherwise engages in deceptive practices will be subject to membership cancellation. The Member may request resolution via the Mediation and Arbitration provisions described in the Guidelines.

F. Pre-Existing Conditions

In short

What if I already have a health condition when I join?

A pre-existing condition only affects bills related to that condition, and it doesn't last forever. Once a condition goes 36 months in a row without signs, symptoms, testing, diagnosis, treatment, or medication, bills for it can be shared. Your other eligible medical bills are shared according to the rest of these Guidelines.

What counts as pre-existing

Pre-Existing Medical Conditions are conditions in which known signs, symptoms, testing, diagnosis, treatment, or use of medication occurred within 36 months prior to membership (based on medical records).

- A known sign is any abnormality indicative of disease discovered on examination/diagnostic testing or known to the member before joining membership.
- A symptom is any subjective evidence of disease. In contrast, a sign is objective.

When it becomes eligible for sharing

A Pre-Existing Medical Condition is eligible for sharing after the condition has gone 36 consecutive months without known signs, symptoms, testing, diagnosis, treatment, or medication (based on medical records).

Here's how that works

Say you take medication for asthma when you join. Asthma is a Pre-Existing Medical Condition, so asthma-related bills aren't eligible for sharing yet. If you go 36 months in a row with no signs, symptoms, testing, diagnosis, treatment, or medication for asthma, those bills become eligible.

Good to know

Controlled blood pressure or cholesterol doesn't rule out heart and vascular sharing. High blood pressure or high cholesterol that's controlled through medication won't be considered a Pre-Existing Medical Condition when we determine eligibility for future vascular or cardiac events.

Perimenopause and menopause aren't pre-existing. See Section I.C.18 for sharing details.

Members 65 and older: Pre-Existing Medical Condition limitations don't apply.

Cancer in remission: If you've been diagnosed with cancer that is in complete remission and you're only having testing for surveillance purposes, bills for those services won't be eligible for sharing for your first 36 months of membership. After 36 months without signs, symptoms, testing (other than surveillance testing), diagnosis, or treatment (medication), medical expenses related to that cancer diagnosis will be eligible for sharing.

Not sure how this applies to you? Take our quick quiz or watch this short video. You can also call our member services team.

G. When Pre-Eligibility is Required

In short

Do I need approval before certain treatments for them to be eligible for sharing?

Cancer treatment, elective heart procedures, non-emergency surgery, transplants, maternity, and MRIs or nuclear imaging need pre-eligibility to be eligible for sharing. Allow 3–5 business days, and make sure we get the medical records we request; without them, the bill isn't eligible.

What needs pre-eligibility

Pre-eligibility is required for any of the following treatments to be eligible for sharing:

- Cancer Treatment
- Elective Cardiac Procedures
- Non-emergency inpatient/outpatient surgery
- Organ/Tissue Transplant Services
- Maternity
- Imaging: MRIs and Nuclear Imaging (e.g., PET scans), not including x-rays or ultrasounds

How to request it

We need 3–5 business days' notice. Expedited review is considered on a case-by-case basis. Medical records are required to determine pre-eligibility. If the requested records aren't provided for review, the bill won't be eligible for sharing.

Providers may request pre-eligibility by calling (855) 378-6777.

Prepayment

When a provider/facility requires payment up front, before care is provided (prepayment), Impact will make every effort to negotiate with the provider/facility to ensure that we obtain a rate that is consistent with our permitted sharing level (120–160% of the Centers for Medicare & Medicaid Services [CMS] rate).

If the provider/facility can't provide a rate that meets our permitted sharing level, we'll make every effort to work with you to find a provider/facility whose fees are closer to our permitted sharing level. The choice of provider is always yours, but if the rate is more than our permitted sharing level, prepayment and sharing are limited to 200% of the CMS rate, and you're responsible for the remaining balance.

If a provider's rate is more than 200% of the CMS rate, there is also a prepayment limit of $500,000 per Member per membership year. These limits exist because prepayment is made with members' shared funds, and we're accountable for those funds on behalf of the entire membership.

Here's how that works

Say the CMS rate for a surgery is $10,000, and the provider requires $25,000 up front. We'll try to negotiate the price down to between $12,000 and $16,000 (120–160% of the CMS rate). If the provider won't lower it and you choose to stay with that provider, prepayment and sharing are limited to $20,000 (200% of the CMS rate), and you're responsible for the other $5,000.



II. Medically Necessary Treatment

In short

How do I know if my treatment is going to be eligible for sharing?

It has to be Medically Necessary, which means the right type and amount of care for your illness or injury, in the least intensive setting that works, and no more costly than other options likely to work as well. A doctor's order doesn't make care Medically Necessary on its own, and maintenance or mainly custodial care doesn't qualify.

What Medically Necessary means

Eligible needs will be approved for sharing when medically necessary. Medically Necessary, which is defined as health care services that are clinically appropriate in terms of type, frequency, extent, site, and duration for the diagnosis or treatment of the member's sickness or injury and ordered by a physician exercising prudent clinical judgment for the purposes of evaluation, diagnosis or treatment of that member's sickness or injury. The Medically Necessary setting and level of service is that which, considering the member's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary, must be no more costly than alternative interventions, including no intervention, and are at least as likely to produce equivalent therapeutic or diagnostic results without adversely affecting the member's medical condition.

Other requirements

- It must not be maintenance therapy or maintenance treatment;
- Its purpose must be to restore health;
- It must not be primarily custodial in nature;

- It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare); and
- Impact reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or eligibility of a Need.
- The mere fact that the service is furnished, prescribed, or approved by a physician does not mean that it is "Medically Necessary."
- The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and Impact's own medical advisors.

Off-label drugs

Off-label drug use is considered Medically Necessary when all of the following conditions are met:

- The drug is approved by the FDA;
- The prescribed drug use is supported by one of the following standard reference sources:
  - DRUGDEX;
  - The American Hospital Formulary Service Drug Information;
  - Medicare-approved compendia; or
  - Scientific evidence is supported in well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the drug is safe and effective for the specific condition; and
- The drug is Medically Necessary to treat the specific condition, including life-threatening conditions or chronic and seriously debilitating conditions.

Good to know

Some treatments, including non-emergency surgery, cancer treatment, and MRIs, need pre-eligibility before you receive them for the bill to be eligible for sharing. See Section I.G.

A. Sharing Limits

In short

Is there a dollar limit on what's eligible for sharing?

Sharing is limited to $50,000 during your first 60 days of membership (excluding pre-existing conditions) and to $150,000 per baby for each pregnancy. Beyond that, ShareRight has no annual sharing cap, and no lifetime limit except where these Guidelines set one.

Your first 60 days

For the first 60 days of membership, up to $50,000 of your Eligible Medical Bills can be shared after your PRA is met (excluding pre-existing conditions). The limit applies to each member, including family members added after you join. This limit does not apply to newborns added within 30 days of birth.

Here's how that works

Say you join on March 1, and a new injury on April 10 brings $70,000 in Eligible Medical Bills. Because that care falls within your first 60 days, no more than $50,000 of those bills can be shared.

Maternity

Maternity sharing is limited to $150,000 per baby for each pregnancy event (for example, $300,000 for twins). See Section I.C.1.

Annual and lifetime limits

There is no annual sharing cap. There is no lifetime limit on sharing except as noted in these Guidelines.

Good to know

Some kinds of care have their own limits. See Section I.C. Limited Sharing.

B. Permitted Sharing Level(s)

In short

Why might only part of my bill be eligible for sharing?

Sharing is limited to the Permitted Sharing Level, a fair price for your care based on recognized standards like Medicare rates, providers' costs, and what's usual for that care. Any amount above that level isn't eligible for sharing. If your bill is lower, sharing is based on the actual bill.

What the Permitted Sharing Level is

"Permitted Sharing Level(s)" means charges for medical care, which is Medically Necessary for the care and treatment of illness or injury, but only to the extent that the fees charged, therefore are within all applicable limitations and restrictions established in the ShareRight Guidelines (the "Guidelines") including, but not limited to, the following:

How it's set for each kind of care

- Hospitals (both inpatient and outpatient services), Ambulatory Surgery Centers, and Independent Facilities: The Permitted Sharing Level for medical care established by the Guidelines shall be based upon the average of 150% of the Medicare allowable amount for the medical care included in the Guidelines and 135% of the cost of the medical care included in the Guidelines; provided, however, that any such Permitted Sharing Level based on the cost of the medical care included in the Guidelines shall be limited to an amount not to exceed 175% of the Medicare allowable amount or the amount of usual, customary and reasonable fees for the medical care included in the Guidelines.
- Other Medical & Surgical Services. The Permitted Sharing Level for any general medical and/or surgical medical care included in the Guidelines not addressed under the immediately preceding subsection or subsection (d) below may be established or calculated taking into consideration and/or based upon the average of: (i) allowable reimbursement amounts for such medical care included in the Guidelines according to the OPPS reimbursement or other Medicare fee payment methodology plus an additional 50%; (ii) the costs for such medical care included in the Guidelines plus an additional 35%; or (iii) the usual, customary and reasonable fees as reflected in, or determined by reference to or through the use of any other industry-standard resources or widely recognized data sources, including any resources listed above or any other fee and/or cost information, sources, lists or comparative data published or publicly available (free, for purchase or by subscription), or any combination of such resources that are sufficient, in the opinion of the claims delegate, to determine a reasonable amount of medical care included in the Guidelines.

- Facilities Lacking Requisite Benchmarks & Specified Services. In the event that for technical reasons Permitted Sharing Levels for medical care included in the Guidelines cannot be determined in accordance with the two immediately preceding subsections, and for other medical care included in the Guidelines specified below, the Permitted Sharing Levels may be determined as follows:
  - Pharmaceuticals. The Permitted Sharing Level for pharmacy charges from any hospital or independent facility may be calculated based on pharmaceutical costs, as follows:
    - 150% of cost for pharmaceuticals other than high-dollar drugs, but not to exceed the usual, customary and reasonable fees for such pharmaceuticals; or
    - 120% of cost for high-dollar drugs; but not to exceed the usual, customary and reasonable fees for such pharmaceuticals.
  - Supplies, Implants & Devices. The Permitted Sharing Level for charges for medical and surgical supplies, implants, and devices may be based upon 120% of the cost to the hospital or independent facility providing such items.
  - Professional Services. The Permitted Sharing Levels for professional services shall be determined based upon the chart for the professional service identified. This chart is available upon request from our Billing Department.
  - Dialysis Services and Infusion Therapy. The Permitted Sharing Level for dialysis services and infusion therapy visits (which shall include dialysis, facility services, supplies, and medications provided during treatment) shall be determined by review of the Medicare allowable amount for the billing hospital or physician in light of clinical considerations pertinent to the patient being treated.
  - Medical Care Provided Under Direct Contract. The Permitted Sharing Levels for medical care provided by directly contracted hospitals or physicians will be the rates or fees established under the applicable contract; provided, however, that the amounts of such rates and fees shall be presumed to be usual, customary, and reasonable only to the extent that they do not include otherwise improper balances, which charges shall be outside of the Permitted Sharing Levels.

When the bill is lower

If the Permitted Sharing Level is more than the actual charge billed for the treatment, service or supply in question, sharing and payments to providers are based on the actual billed charge. The Permitted Sharing Level for medical care will not include charges related to unbundling, errors, unclear description or misidentification.

Here's how that works

Say the Permitted Sharing Level for an MRI is $900, but your provider bills $700. Sharing and payment to the provider are based on the $700 bill.

Medically Necessary

Eligible needs will be approved for sharing when medically necessary. Medically Necessary, which is defined as health care services that are clinically appropriate in terms of type, frequency, extent, site, and duration for the diagnosis or treatment of the member's sickness or injury and ordered by a physician exercising prudent clinical judgment for the purposes of evaluation, diagnosis or treatment of that member's sickness or injury. The Medically Necessary setting and level of service is that which, considering the member's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary, must be no more costly than alternative interventions, including no intervention, and are at least as

likely to produce equivalent therapeutic or diagnostic results without adversely affecting the member's medical condition.

- It must not be maintenance therapy or maintenance treatment;
- Its purpose must be to restore health;
- It must not be primarily custodial in nature;
- It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare); and
- Impact reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or eligibility of a Need.
- The mere fact that the service is furnished, prescribed, or approved by a physician does not mean that it is "Medically Necessary."
- The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and Impact's own medical advisors.

Off-label drugs

Off-label drug use is considered Medically Necessary when all of the following conditions are met:

- The drug is approved by the FDA;
- The prescribed drug use is supported by one of the following standard reference sources:
  - DRUGDEX;
  - The American Hospital Formulary Service Drug Information;
  - Medicare-approved compendia; or
  - Scientific evidence is supported in well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the drug is safe and effective for the specific condition; and
- The drug is Medically Necessary to treat the specific condition, including life-threatening conditions or chronic and seriously debilitating conditions.

Prepayment

When a provider/facility requires payment up front, before care is provided (prepayment), Impact will make every effort to negotiate with the provider/facility to ensure that we obtain a rate that is consistent with our permitted sharing level (120–160% of the CMS rate).

If the provider/facility can't provide a rate that meets our permitted sharing level, we'll make every effort to work with you to find a provider/facility whose fees are closer to our permitted sharing level. The choice of provider is always yours, but if the rate is more than our permitted sharing level, prepayment and sharing are limited to 200% of the CMS rate, and you're responsible for the remaining balance.

If a provider's rate is more than 200% of the CMS rate, there is also a prepayment limit of $500,000 per Member per membership year. These limits exist because prepayment is made with members' shared funds, and we're accountable for those funds on behalf of the entire membership.

Here's how that works

Say the CMS rate for a surgery is $10,000, and the provider requires $25,000 up front. We'll try to negotiate the price down to between $12,000 and $16,000 (120–160% of the CMS rate). If the provider won't lower it and you choose to stay with that provider, prepayment and sharing are limited to $20,000 (200% of the CMS rate), and you're responsible for the other $5,000.

C. Approved Treatment

In short

Does it matter who orders my care or where I get it for my bill to be eligible for sharing?

Your care has to be CMS- or FDA-approved, ordered by one of the providers listed below, and received in the U.S. at a hospital, surgery center, clinic, doctor's office, or diagnostic facility. Care outside the U.S. is eligible only for a medical emergency, and you'll need to provide the records that show it.

Who can order your care

To be eligible for sharing, testing and treatment must be CMS- or FDA-approved and submitted on a CMS 1500 or a UB and IB form, and ordered by a:

- Medical Doctor (M.D.)
- Doctor of Osteopathy (D.O.)
- Nurse Practitioner (N.P. or A.P.R.N.)
- Physician's Assistant (P.A.)
- Doctor of Podiatric Medicine (D.P.M.)
- Midwife
- Ophthalmologist
- Doctor of Chiropractic (D.C.)

Where your care happens

These CMS or FDA-approved tests and treatments must occur at one of the following:

- Hospital
- Surgery center
- Clinic
- Doctor's office
- Diagnostic facility

Care outside the U.S.

Diagnosis and treatment must be performed in the U.S. to be eligible for sharing. Medical bills from care received outside the U.S. are only eligible for sharing when the need is the result of a medical emergency (as defined in the Glossary of Terms).

If you receive emergency care outside the U.S., you're responsible for providing the supporting documentation needed to determine eligibility for sharing. Any costs of getting necessary records or documentation are your responsibility.

Good to know

Note: This may not apply to the Senior program, as sharing is secondary to Medicare, and Medicare may or may not pay for medical treatments outside of the country.

D. Use of Programs



In short

What if I qualify for other help with my bill? Does that keep it from being eligible for sharing?

Not if you apply for that help first. When you qualify for public assistance or a private benevolence program, your bill can be considered for sharing only after you apply for that assistance. When a program does help, the Share Portion of your next three months is waived.

Apply for other help first

If you qualify for public assistance or private benevolence programs, you must apply for the program benefit before the bill can be considered for sharing. The organization that runs the program, such as a government agency or hospital, decides whether you qualify. While your application is pending, your bill is on hold. Once the program decides, only the part it doesn't cover can be considered for sharing.

When a program helps

If you receive assistance through the use of a program, the next three months of your monthly Share Portion will be waived, starting the month after you receive assistance.



III. Program Details

A. Healthcare Sharing

In short

How is my monthly share amount set?

Your monthly share depends on the age of the oldest person in your household, how many people are on your membership, the PRA you choose, and whether you choose a 0% co-share. Some members also pay a BMI Assessment or a Tobacco Assessment, but neither applies to members 65+. Your share goes toward other members' Eligible Medical Bills.

Your monthly share

To participate, you contribute a Monthly Share Amount that is applied to the Eligible Medical Bills of other members. Your Monthly Share Amount is based on the age of the oldest member in your household, the number of people applying (1, 2, or 3 or more), and your choice of Annual Household Primary Responsibility Amount (PRA). If you choose a 0% co-share (see Section III.C), your Monthly Share Amount also includes $35 per member per month, for up to three members.

Assessments

If certain criteria are met, a Body Mass Index (BMI) Assessment of $125 per month will also be applied. If you use tobacco or vape regularly, you're required to pay a Tobacco Assessment of $50 per month. The BMI Assessment and Tobacco Assessment do not apply to the Senior (65+) program.

To review your monthly share options, use the pricing calculator **[link to come]**. Watch a video on how sharing works **[link to come]**.

B. Primary Responsibility Amount (PRA)

In short

How much does my household pay toward our own bills before sharing starts?

Your PRA is the dollar amount your household chooses when you join. Each membership year, you pay your household's Eligible Medical Bills until they add up to that amount, with everyone on your membership counting toward the same PRA, and after that your bills can be published for sharing. The count starts over each year on your Membership Date. Your annual wellness visit and lab allowance are the exception, because they can be shared even before your PRA is met.

What the PRA is

The Primary Responsibility Amount (PRA) is the dollar amount a Member Household must pay toward their own Eligible Medical Bills during a 12-month period before their Eligible Medical Bills can be published and shared by the membership.

What it applies to

All Eligible Medical Bills are subject to the annual PRA and co-share (if applicable) except the annual/well office visit and lab allowance as detailed in Section I.C.13. The PRA 12-month period begins on the Membership Date.

When it resets

The PRA resets on the anniversary of your Membership Date. Your Membership Date is the date that your ShareRight membership started.

Here's how that works

Say your Membership Date is March 1 and your household's PRA is $5,000. In May, you pay $3,000 in Eligible Medical Bills. In August, you have $4,000 more in Eligible Medical Bills. You pay the first $2,000 to finish your PRA, and the other $2,000 can be published for sharing, subject to co-share (if applicable). On March 1 next year, your PRA starts over.

Changing your PRA

You can raise or lower your PRA amount on the anniversary of your Membership Date.

To compare PRA and co-share options, use the pricing calculator **[link to come]**.

C. Co-share

In short

Once my household's PRA is met, do I still pay part of my bills?

After your PRA is met, you still pay 10% of your Eligible Medical Bills, called your co-share, and the other 90% is published for sharing. You can choose to pay $35 per member per month, for up to three members, to lower that co-share to 0%. That choice doesn't change how prescriptions or Limited Sharing categories are shared.

After your PRA is met

Once the Primary Responsibility Amount is met, you pay 10% (the Co-share amount) of all Eligible Medical Bills. The remaining 90% is published for sharing to the membership.

Choosing a 0% co-share

You can choose to pay an additional $35 per member per month, for up to three members, to reduce the co-share above to 0%. This choice applies to your whole membership. A couple pays for two members, and a family pays for three, even if more people are on the membership. It doesn't change how prescriptions or Limited Sharing categories (Section I.C) are shared, and Provider Fees (Section III.E) still apply. You can make this choice when you join or on the anniversary of your Membership Date.

Here's how that works

Say your household has met its PRA, hasn't reached its co-share limit, and has a $2,000 Eligible Medical Bill to treat a broken arm. You pay $200 (10%), and $1,800 is published for sharing. If you've chosen a 0% co-share, the full $2,000 is published for sharing.

To compare PRA and co-share options, use the pricing calculator **[link to come]**.

D. Co-share Limit

In short

Is there a limit on how much co-share my household pays each year?

Your household's co-share is limited to $5,000 a year. Once you've paid that much, you won't pay co-share again until it resets on your Membership Date.

Your yearly co-share limit

There is a co-share limit of $5,000 per household per year. In other words, after your household pays a total of $5,000 in co-shares, you will not be subject to a co-share until the amount resets on your Membership Date.

Here's how that works

Say your household has met its PRA and has already paid $4,800 in co-share this year. You then have a $5,000 Eligible Medical Bill. You pay $200, which brings you to the $5,000 limit, and the remaining $4,800 is published for sharing.

Good to know

If you've chosen a 0% co-share (see Section III.C), you won't pay the 10% co-share, so this limit only matters for any co-share you still pay.

E. Provider Fee

In short

What do I pay when I see a provider?

At each visit, you pay a set Provider Fee, from $0 for virtual care and outpatient therapy up to $150 for an ER visit or hospital stay. Provider Fees don't count toward your PRA, and you still pay them after your PRA is met.

Your Provider Fee at each visit

At the time you receive service from a medical care provider, you pay the following:

- $0 (Provider Fee waived) for Virtual Telehealth
- $0 (Provider Fee waived) for Virtual Short-Term Teletherapy (See limitations in Section I.C.4)
- $0 (Provider Fee waived) for Outpatient Therapy (See limitations in Section I.C.5)
- $50 for Primary Care
- $50 for each Allergy Test/Serum Injection
- $75 for Specialist/Urgent Care
- $150 for Emergency Room or Inpatient Hospitalization.



How fees, PRA, and co-share fit together

These fees are not applied to the annual PRA and apply even if you've met the annual PRA for the year. For eligible services, the Provider Fee is applied, then any remaining annual PRA, and finally, the Co-share (if applicable) is applied up to the Co-share limit. Provider Fees don't apply to members 65 and older.

Here's how that works

Say your household has met its PRA and hasn't reached its co-share limit, and a specialist visit brings a $575 Eligible Medical Bill. At the visit, you pay the $75 Provider Fee, which is part of that bill. That leaves $500. You pay 10% of it ($50) as your co-share, and the other $450 is published for sharing. In all, you pay $125 of the $575. If you've chosen a 0% co-share, you pay only the $75 fee, and the full $500 is published for sharing.

Virtual Care

Virtual Care is shared on equal footing with all other medical expenses but the provider fee is waived at time of service. Virtual Care is subject to all other limitations of health sharing costs and is not a promise to pay or provide that service by either Impact or its membership. As with all other medical costs and expenses, contribution to Virtual Care remains voluntary.

F. Guidelines Govern

In short

Which version of the Guidelines applies to my bill?

The Guidelines in effect on the date you receive care decide whether your bill is eligible for sharing, not the ones in effect when you joined. You can always find the current Guidelines online.

The Guidelines in effect when you receive care

These Guidelines explain the program requirements and govern the sharing of medical bills. The Guidelines in effect at the time of service govern the program, not the Guidelines in effect when you join.

Here's how that works

Say you join in January and the Guidelines change in July. If you have surgery in September, the July Guidelines apply to that bill.

Where to find them

The Guidelines are available online at ShareRight.org.

G. Changes to the Guidelines

In short

Do the Guidelines ever change?

The Guidelines can change at any time by a majority vote of Impact's Board of Directors. We'll let members know about any change, and each change stays posted online for 24 months.

Who can change them

Changes to the Guidelines can be made by a majority vote of Impact's Board of Directors at any time.

How you'll hear about changes

We'll notify members of the changes, and all changes will be available at ShareRight.org for 24 months from the date of the change.

H. No Member or ShareRight Liability

In short

Who is responsible for paying my medical bills?

You are responsible for your own medical bills. Neither ShareRight nor Impact Health Sharing is insurance, and neither they nor other Members are required to pay your bills. When bills are shared, they're paid from other Members' contributions, not from ShareRight's or Impact's own funds.

Healthcare sharing is not insurance

ShareRight is a program of Impact Health Sharing. Neither ShareRight nor Impact Health Sharing is insurance. Impact Health Sharing is a Healthcare Sharing Organization as outlined in the Patient Protection and Affordable Care Act and was created to facilitate the sharing of medical bills and expenses among Members, one with another, according to these Guidelines, in Impact's reasonable discretion. Neither ShareRight nor Impact Health Sharing is liable for the payment of a Member's medical bill. If sharing occurs, the shared medical bills are paid by the Member who incurred the bill from other Members' share contributions only, not from funds of ShareRight or Impact Health Sharing itself.

SHARERIGHT IS NOT AN INSURANCE COMPANY. IMPACT HEALTH SHARING IS NOT AN INSURANCE COMPANY. HEALTH SHARING IS NOT INSURANCE OR A CONTRACT FOR INSURANCE. THE PAYMENT OF MEDICAL BILLS THROUGH SHARERIGHT, IMPACT HEALTH SHARING, OR OTHERWISE IS NOT GUARANTEED IN ANY WAY.

No transfer of risk

There is no transfer of risk from a Member to ShareRight or Impact Health Sharing, or from a Member to other Members; and there is not a contract of indemnity between ShareRight or Impact Health Sharing and any Member or between the Members themselves.

I. Pilot Programs

In short

What are Pilot Programs, and can I join one?

Pilot Programs are open only to the groups of Members ShareRight selects to test something new. Taking part is voluntary, and what a Pilot Program offers ends when the program ends.

What Pilot Programs are

ShareRight may, with Impact Health Sharing's approval, offer Pilot Programs to any segment or group of Members to test the feasibility of new proposals and programs. The benefits offered in a Pilot Program may not be available to the entire Membership.

Who can take part

If you're not selected for a Pilot Program, you're not entitled to its benefits unless and until ShareRight opens the Pilot Program to the entire Membership. If you receive benefits through a Pilot Program, you're no longer entitled to those benefits once the Pilot Program ends.

Participation in a Pilot Program is entirely voluntary.

Any Pilot Program that is eventually opened to the entire Membership may also be ended by ShareRight without notice.



IV. Membership

A. Qualifications

In short

Who can join ShareRight?

To join ShareRight, you can't have used Illegal Drugs in the 12 months before you apply. You also need to agree with the two statements that open these Guidelines, the Impact community's Statement of Shared Beliefs & Ethics and the ShareRight Statement of Faith.

Who can join

To be eligible to participate in ShareRight, an applicant must:

- Have abstained from the use of Illegal Drugs for at least 12 months prior to applying for membership
- Agree with the Impact community's Statement of Shared Beliefs & Ethics and the ShareRight Statement of Faith outlined in these Guidelines

Good to know

Members 65 and older have more qualifications, including Medicare. See Section IV.D.

B. Membership Requirements

In short

What does my household agree to when we become members?

Everyone on your membership, including adult children 18 to 25, must stay free of Illegal Drugs. If anyone leaves out medical history or lifestyle habits that could disqualify them and it's found later, bills may not be shared and the membership may be canceled. You pay your monthly share online by EFT, and some Members pay an extra monthly assessment for tobacco use or BMI.



Staying free of Illegal Drugs

Members cannot use Illegal Drugs.

Adult children

An adult child (18–25) needs to meet the same requirements in order to be on his or her parent(s)' household membership and have their bills shared.

Disclosing your medical history

Medical information is provided during the application process. IF AN APPLICANT OR MEMBER FAILS TO DISCLOSE MEDICAL HISTORY OR LIFESTYLE HABITS OR CHOICES THAT MAY DISQUALIFY THEM FROM MEMBERSHIP AND THAT INFORMATION IS DISCOVERED, MEDICAL BILLS MAY NOT BE SHARED AND/OR MEMBERSHIP MAY BE CANCELLED.

Paying your monthly share

Participation in ShareRight will be online, and monthly share Contributions must be made using Electronic Funds Transfers (EFTs). The Contributions will be electronically transferred from the Member's bank account to a Virtual Share Account in order to send funds to other Members. Receiving Members will receive those funds in bill-pay accounts, the sole purpose of which will be to pay eligible bills.



Body Mass Index (BMI) Assessment

Established Body Mass Index (BMI) assessment criteria (based on weight and height) may require applicants to pay an additional monthly amount of $125. In order to remove this additional amount, Members must provide documentation that shows they have lowered their BMI below the set criteria. You will be notified during the application process, before you join, if you qualify for this additional amount. The BMI Assessment does not apply to the Senior (65+) Program.

Here's how that works

Say your BMI is above the set criteria when you apply. You're told before you join, and you pay an extra $125 a month. Later, you lower your BMI below the criteria and send documentation that shows it. Then the extra $125 can be removed.

Tobacco Use Assessment

Members who use tobacco or vape regularly are required to pay a Tobacco Assessment of $50 per month for each member who uses tobacco.

Members who do not disclose this information may be subject to membership termination if it is determined after the Membership Date.

You will be notified during the application process, before you join, if you qualify for this additional amount. The Tobacco Assessment does not apply to the Senior (65+) Program.

C. Family Members

In short

Who in my family can be on our membership?

Your spouse, your unmarried children until they turn 26, and children in your full legal custody or guardianship can be on your membership, as long as each one meets the qualifications for membership. They can be included when you join or added later. A child who has a disability and still depends on your care can stay on after turning 26. If your daughter becomes pregnant, she starts her own ShareRight membership so she and her baby have their own household. She stays a Member and keeps her original eligibility, and her maternity bills are shared under her own membership.

Who can be on your membership

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

- Spouse
- Unmarried Children (Biological or Adopted) until they reach the age of 26*
- Children in full legal custody or guardianship of the Member

*An exception is made for those who are disabled and still dependent upon and under the care of their parent(s). Documentation that states the disability and names the guardian is required.

When a dependent on your membership is pregnant

If a dependent on your membership (other than a spouse) becomes pregnant, her maternity bills can be shared only under her own individual ShareRight membership, which starts once her pregnancy is confirmed at her first prenatal appointment. She remains a Member and doesn't need to reapply, but she'll be asked to sign and attest to the membership disclosures. If she's under 18, a parent or legal guardian signs on her behalf. For her new membership, she chooses her own PRA and pays her own Monthly Share Amount. For eligibility, including her pregnancy, her original Membership Date still applies, and the 60-day sharing limit in Section II.A doesn't apply to her. Her baby can be added to her membership from the date of birth (see Section I.C.1).

We'll walk her through the change and help her look at all her options.

Good to know

Adult children 18 to 25 need to meet the same requirements as other Members (see Section IV.B). A child's membership ends at the end of the month they turn 26. If you've chosen a 0% co-share, you pay for no more than three members, even if more family members are on your membership (see Section III.C).

D. 65 Years of Age and Older

In short

Do I need Medicare to join if I'm 65 or older?

If you're 65 or older, you must have Medicare Parts A and B to join, plus Part D for your prescription bills to be eligible for sharing. Medicare pays first, and sharing is secondary to it. You join on your own, not as part of a household, and there's one PRA level for Members 65 and older.

Medicare

Applicants who are age 65 or older must have Medicare Parts A&B. For prescription costs to be eligible for sharing, Members must have Medicare Part D as well. All sharing will be secondary to Medicare.

PRA and membership

There is only one PRA level available to these senior adults: $1,000 (see the pricing calculator **[link to come]**). The Senior (65+) Program is available only on an individual membership basis.

Important Notice Regarding Medigap Coverage

If you cancel a Medigap policy (Medicare Supplement Insurance) to join the ShareRight community (a program of Impact Health Sharing), you will not have Guaranteed Issue Rights if you re-apply for Medigap coverage in the future. Guaranteed Issue Rights allow Medicare beneficiaries to buy certain Medigap plans without medical underwriting (health screenings). Without Guaranteed Issue Rights, you could be denied coverage, face higher premiums, or be subject to enrollment waiting periods.

Good to know

The BMI and Tobacco Assessments don't apply to Members 65 and older (see Section IV.B).

E. Non-U.S. Citizens

In short

Can I join if I'm not a U.S. citizen?

You can join if you have a Social Security number or an ITIN, along with the right ID. With a Social Security number, you need a valid ID card issued by the U.S. or a state. With an ITIN, you need a government-issued ID card from Mexico, Canada, or Guatemala.

Who can join

The following individual(s) can join ShareRight.

- Those who possess a U.S.-issued Social Security number and a valid Identification Card issued by the U.S. or a state government.
- Those who possess an Individual Taxpayer Identification Number (ITIN) and also have a government-issued Identification Card issued by Mexico, Canada, or Guatemala.

F. Late Fees and Cancellation Policy for Failure to Deposit Monthly Share

In short

What happens if my monthly share is late?

If your monthly share is more than 30 days late, you're charged a $25 late fee. If it's more than 60 days late, your membership is canceled as of the last day of the last month you paid for, and only bills from on or before that date are considered for sharing. If you want to cancel, let us know by the last day of the month.

Late fee

A $25 late fee will be assessed if you do not deposit the Monthly Share within 30 days after the due date.

Cancellation for nonpayment

Your membership will be canceled if you do not deposit the Monthly Share within 60 days after the due date. The Cancellation Date will be retroactive to the last day of the month for which the last Monthly Share was deposited. Only Eligible Medical Bills incurred on or before the Cancellation Date will be considered for sharing.

Here's how that works

Say you've paid your monthly share through February 2027, and March's share isn't paid. If it's still unpaid 30 days after its due date, a $25 late fee is added. If it's still unpaid 60 days after its due date, your membership is canceled, and the Cancellation Date goes back to February 28, 2027. A bill for care on February 20 can still be considered for sharing. A bill for care on March 15 can't.

Canceling your membership

You must notify us of your intent to cancel by the last day of the month. You may contact us by phone at (855) 610-2805 or by email at support@shareright.org.

To cancel or ask about a late payment, contact member services at (855) 610-2805 or support@shareright.org.

G. Third-Party Fiduciary Assessment Fee

In short

Why was a $100 fee added to my monthly share?

If the ID documents you give at enrollment don't meet the requirements of America's Christian Credit Union (ACCU), you have 30 days to send what it needs. After that, a $100 fee is added to your Monthly Share Amount until you send them. Once you do, Impact refunds the fee.

Your share account

Member share payments are deposited into Member-owned, not Impact-owned, bank accounts opened by the Member at enrollment with our third-party fiduciary, America's Christian Credit Union (ACCU). To complete the account setup, ACCU requires verification of identity.

Verifying your identity

If the documents provided at enrollment do not meet ACCU's requirements, you will be notified by Impact and will have 30 days to provide the identity verification documents. After 30 days, a $100 assessment fee will be applied to the Monthly Share Amount until the requested identity verification documents have either been emailed to support@shareright.org or uploaded by you in the Member Center. Note: Impact will refund the assessment fee or fees once you provide the requested documents.

Here's how that works

Say you're notified that ACCU needs another ID document. If you send it within 30 days, no fee is added. If you send it later, a $100 fee is applied to your Monthly Share Amount until you do, and Impact refunds it once you've sent the documents.



V. Conditions of Sharing

A. ShareRight Is Not a Substitute for Insurance as May Be Required by Law

Can ShareRight take the place of insurance the law requires me to have?

Not insurance

ShareRight is a program of Impact Health Sharing. Neither ShareRight nor Impact Health Sharing is insurance. However, ShareRight may be used as a substitute for or an exemption from mandated insurance coverage in the following circumstances:

- To satisfy the federal mandate that became effective January 1, 2014, requiring "applicable individuals" to maintain "minimum essential [insurance] coverage"
- To satisfy a certain state requirement to maintain "minimum creditable [insurance] coverage"

Other insurance required by law

These are the only exceptions. Otherwise, Members must not certify that ShareRight is insurance to avoid purchasing insurance required by law, rule, or regulation, for example, workers' compensation insurance or sports activity insurance.

B. Sharing Is Secondary to Other Sources

What if I have insurance or other help that could pay my bill?

Other sources come first

If you have insurance or are eligible or qualified for any insurance benefits or other health or welfare benefits, such as an employment-related health or welfare plan, workers' compensation insurance, homeowner's insurance, a third party's liability insurance, or fraternal benefits, you are expected to take all reasonable steps to qualify for such payments and to exhaust benefits available under those resources before submitting a request for sharing.

C. Assignment of Third-Party Claims

What if someone else is responsible for my injury or illness?

Assigning your rights

In certain instances where a sharing event may have been caused by actions of a third party, the Member may be required to assign to Impact Health Sharing and/or ShareRight any and all rights that Member has against all parties responsible for causing the injuries or illnesses. This is up to the total amount Members provided to or for the benefit of the Member and to reimburse Impact Health Sharing and/or ShareRight on behalf of Members. This includes any and all amounts Members provide to or on behalf of a Member as a result of injuries or illnesses which result from the actions or liability of a third party, and/or which result in a settlement, judgment, or other award or recovery to or by a Member.

D. Sharing Appeal

What if I disagree with a decision about my bill?

When you can appeal

A Member can appeal bill-sharing decisions with which they disagree if he or she believes:

- the medical records were misread, or
- the Guidelines were misapplied.

Appeal Panel review

After a review by Impact Health Sharing, if the Member disagrees with Impact Health Sharing's decision, the Member has 90 days from the date Impact Health Sharing issues its final decision on the bill to request a review by a Seven Member Appeal Panel established by Impact Health Sharing. The panel is made up of seven Members selected at random. Impact Health Sharing 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 Impact Health Sharing. A simple majority vote (four out of seven) will carry the decision to share or not.

To start an appeal, email support@shareright.org with your medical records and the reason for your appeal.

E. Mediation and Arbitration

What if I still disagree after an appeal?

How the Guidelines work

While these Guidelines are not a contract for insurance, the Guidelines do outline the manner in which voluntary sharing occurs among Members under the ShareRight program and Impact Health Sharing. Further, you have authorized Impact Health Sharing to exercise reasonable discretion to administer the ShareRight program according to these Guidelines.

Mediation

Any claim or dispute arising out of, or related to, these Guidelines or against ShareRight and/or Impact Health Sharing or any of its directors, officers, agents, employees, or contractors after a Member has exhausted his or her appeals provided for in Section V(D) shall be directed to mediation in Broward County, Florida before a single mediator selected by Impact Health Sharing's Board of Directors with the costs of such mediation being split equally among the disputing parties.

Arbitration

In the event that such dispute is not resolved within 30 days of such mediation, then such dispute will be finally settled by binding arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association then in effect by a single arbitrator appointed by Impact Health Sharing in accordance with said rules in Broward County, Florida. Except by agreement of the parties, the arbitration hearing shall begin within 90 days of the date that such arbitrator conducts his or her initial hearing in the matter. Further, unless agreed to in writing by the parties, the time allotted for such hearing shall not exceed five business days, and the parties shall have an equal time to present evidence at such hearing. The determination of the arbitrator will be final and binding upon the parties to such arbitration, and judgment upon the award rendered by the arbitrator may be entered in any court having competent jurisdiction. The costs of arbitration shall be borne equally by all parties involved; provided, however, the arbitrator may assess all costs of such dispute (including reasonable attorneys' fees) against one party in the event that the arbitrator determines that such party caused such dispute to be brought to arbitration through his or her bad faith or frivolous action or inaction. Any additional costs that a party may incur during the course of and relating to the arbitration will be borne solely by the party that incurs the same including, without limitation, such party's respective incurred attorneys' fees.

Injunctive relief

Notwithstanding the foregoing, any party may seek injunctive relief with respect to any dispute, claim, or controversy arising out of or relating to this Agreement in the courts located in Broward County, Florida and the parties hereto hereby irrevocably submit to the exclusive jurisdiction of such courts for the purpose of this Section V(E).

Waiver of lawsuits and class actions

MEMBERS AGREE THAT THESE METHODS OF DISPUTE RESOLUTION SHALL BE THE SOLE REMEDY FOR ANY DISPUTE, CLAIM, OR CONTROVERSY ARISING OUT OF OR RELATING TO THESE GUIDELINES OR AGAINST SHARERIGHT OR IMPACT HEALTH SHARING OR ANY OF ITS DIRECTORS, OFFICERS, AGENTS, EMPLOYEES, OR CONTRACTORS, AND SUCH MEMBERS, SHARERIGHT, AND IMPACT HEALTH SHARING EXPRESSLY WAIVE THEIR RESPECTIVE RIGHTS TO FILE ANY LAWSUIT IN ANY CIVIL COURT AGAINST ONE ANOTHER (OTHER THAN FOR THE PURPOSE OF SEEKING INJUNCTIVE RELIEF PURSUANT TO THE FOREGOING PARAGRAPH) AND THE RIGHT TO PURSUE ANY CLASS OR REPRESENTATIVE CLAIMS AGAINST EACH OTHER IN COURT, ARBITRATION, OR ANY OTHER PROCEEDING, WITH FULL KNOWLEDGE OF THE CONSEQUENCES OF SUCH WAIVER. THE ARBITRAL TRIBUNAL MAY NOT CONSOLIDATE MORE THAN ONE PERSON'S CLAIMS AND MAY NOT OTHERWISE PRESIDE OVER ANY FORM OF A REPRESENTATIVE OR CLASS PROCEEDING TO THE FULLEST EXTENT ALLOWABLE BY LAW. IN THE EVENT THAT THIS PROHIBITION ON CLASS ACTIONS OR CLASS ARBITRATIONS IS DEEMED INVALID OR UNENFORCEABLE, THEN THE REMAINING PORTIONS OF THIS SECTION V(E) WILL REMAIN IN FULL FORCE AND EFFECT.

F. Negotiated Settlement Agreements

What do I have to pay if my provider settles my bill?

When a settlement is needed

On rare occasions, a provider and/or its billing agent may require Impact Health Sharing to enter a negotiated settlement agreement to fully clear an outstanding bill incurred by you.

What you pay, and when

In such cases, Impact Health Sharing will share a specific amount toward the outstanding bill as per the Guidelines and the settlement agreement, and you will be required to pay the remaining balance that represents your Primary Responsibility Amount (PRA) and co-share (if applicable). In such a case, Impact Health Sharing will be unable to release sharing funds to the provider until you have fully paid your PRA and co-share (if applicable) in the amount specified in the negotiated settlement agreement.

If the settlement falls through

If you don't produce these funds within the timeline outlined in the settlement agreement, the provider and/or its billing agent can declare the settlement agreement null and void. If the agreement is null and void and a new settlement agreement must be made, Impact Health Sharing will only share the lesser amount of the agreements, and the remaining balance will be your responsibility.



VI. Virtual Share Exchange

What is the Virtual Share Exchange, and why do I need it?

The platform and your permission

To make Healthcare Sharing convenient and efficient, Impact Health Sharing deploys a technology platform called a Virtual Share Exchange ("VSE"). The VSE enables all ShareRight Members to participate in the Healthcare Sharing process electronically, as well as to monitor the transactional activities of their individual Share Accounts and the community at large. Your ShareRight membership requires that you activate your own Share Account and enable the Virtual Share Exchange to administer the sharing process on your behalf. By activating your Share Account and accepting the Virtual Share Exchange "Terms and Conditions" and Disclosures, you have given Impact Health Sharing and its Service Agents express permission to conduct financial transactions necessary for the administration of the program on your behalf.

A. Share Account

What is my Share Account, and how do I set it up?

What your Share Account is

To participate in the ShareRight program, all Members must activate a Share Account on the Virtual Share Exchange Platform. Your Share Account is a virtual account, and all deposited funds are received by America's Christian Credit Union, which holds them "For the Benefit of Impact Health Sharing Members." The Share Account will display your account balances, share transaction history, and other relevant information, and include your own dashboard management tools. The money in your Share Account is insured in the event America's Christian Credit Union becomes insolvent (see disclosure at ShareRight.org).

Setting it up

To activate your Share Account, you will be required to provide the necessary personal information to comply with U.S. Banking Regulations. Once your information is submitted and verified, you will be required to link your Share Account to one of your External Bank Accounts. Each month, you will fund your Share Account with an EFT (Electronic Funds Transfer) from your External Bank Account.

B. Monthly Share Notice

How does my household know what to pay each month?

Your notice

ShareRight Members will receive a Monthly Share Notice through the VSE Platform to inform them and remind them of the monthly amount that they are to contribute. The monthly amount that you are to contribute (your Total Share Amount Due) is based on the ShareRight program level that you have selected.

What's included

The amount specified in your Monthly Share Notice is transferred through an EFT drawn from your External Bank Account. EFTs are always for the "Total Share Amount Due." The "Total Share Amount Due" is displayed on every Monthly Share Notice, and it will include the current Monthly Share Amount, any Past Due Amounts, and any relevant Service Fees.

Paying it

The Total Share Amount Due may be paid manually within the VSE Platform or through Recurring EFTs that you configure within the system. You will have the ability to add, edit, and delete your Recurring EFTs, as well as your linked External Bank Account, at any time.

C. Account Management

Who controls my Share Account, and what is the money in it for?

Your controls

Your Share Account is a financial account that you own and control. You will have the ability to add, edit, and delete your Recurring Electronic Funds Transfer (EFT) settings, as well as your linked External Bank Account, at any time. You may also choose to have your medical bills "anonymously" shared among the membership, otherwise Members who share in your medical bills will be able to see with whom they are sharing.

What the money is for

Please note that the funds in a Member's Share Account are not intended for the payment of the Member's own medical bills, expenses, or Annual Household Primary Responsibility Amount (PRA). Instead, these funds are designated for Member-to-Member, or peer-to-peer (P2P), sharing. This means that each Member contributes to the medical needs of other Members, rather than drawing from a collective fund for their own expenses.

No refunds

Additionally, the balance in a Member's Share Account is not refundable upon cancellation or termination of membership, as those funds have already been committed to the sharing community in accordance with the principles and guidelines of the program.

D. Publishing & Sharing

How does my bill get shared, and what if I don't want to share in someone else's?

Sharing is voluntary



Participation in the ShareRight sharing community is voluntary. This means that when you are selected to participate in a sharing event, if you object to that particular sharing event for any reason, you may withdraw and terminate your membership during the three-business-day Publishing Period (described below) rather than participate in that sharing event.

Peer-to-peer sharing

Medical Bills that are Eligible for Sharing are matched, allocated, and published to the membership prior to sharing. To be compliant with regulations and safe harbor statutes, Impact Health Sharing implements a Member-to-Member or peer-to-peer (P2P) approach to sharing, which means that Members share funds directly with one another rather than drawing funds from a pool.

How your bill moves

Your medical bills may be submitted to Impact by your Medical Providers, or you can submit them through the Member Center. Either way, making sure your bills are submitted is your responsibility (see Section I.B). Impact will process all bills for eligibility per the Guidelines. Eligible bills are then submitted into the Virtual Share Exchange for sharing. Amounts Approved for Sharing are allocated to your fellow Members who have been matched to share in (contribute toward payment of) your bill.

Publishing

Members who have been matched to share your bill will be notified through a process called "publishing" as to the amount that will be withdrawn from their Share Account for the payment of your bill. They will also be notified as to who will be receiving their funds unless you choose the anonymous setting in your Share Account dashboard's Sharing Permissions. Once the three-business-day Publishing Period has ended, the amount published to each Member is transferred to a Virtual Bill Account for the payment of your bill.

Withdrawing instead of sharing

Members who have been matched and allocated to share in another Member's medical bill may withdraw from membership prior to the expiration of the three-business-day Publishing Period, in which case no funds will be transferred to the receiving Member.

Because a Member may refuse to share in a particular medical expense for any reason or no reason, the sharing process remains entirely voluntary for every Member. However, as noted above, any sharing refusal requires withdrawal from membership before the end of the three-business-day Publishing Period.

E. Virtual Bill Accounts

Where is the money shared for my bill held until my provider is paid?

Your Virtual Bill Account

If you have an Eligible Medical Bill that has been approved for sharing, the VSE will create a Virtual Bill Account for the payment of that bill. Virtual Bill Accounts are unique to a specific medical bill and are linked to your Share Account. Each Virtual Bill Account is unique to a member of your household, a medical provider, and a specific bill. Amounts collected in your Virtual Bill Account(s) are restricted and are displayed as a single line item transaction in your Share Account.

F. Provider Payments

When does my provider get paid?

Paying your provider

Virtual Bill Accounts remain open until the Amount Approved for Sharing has been fully collected and transferred to your Medical Provider as payment for your bill. While Virtual Bill Accounts are aggregated in the transactional view of your Share Account, these funds are restricted and cannot be withdrawn from your Share Account. Once all the allocated funds have been transferred from the Members who were matched to pay your medical bill, those funds are released for payment to your Medical Provider. The transfer of funds out of your Virtual Bill Account will be displayed as a single line item transaction in your Share Account.

G. Distributed Reserves

Why does my Share Account keep a balance?

How reserves work

In order to process and pay medical bills quickly, Impact Health Sharing implements a practice called “Distributed” or “Decentralized” Reserving. Neither ShareRight nor Impact Health Sharing is insurance, so we do not collect and hold medical reserves in a centralized bank account. Instead, the Monthly Share Amount is set at a level to build a small balance (or reserve) in every Member’s individual Share Account. These “Distributed Reserves” enable Impact Health Sharing to better manage the ebb and flow of medical usage and payments.



Glossary of Terms

BASIC TERMS UNIQUE TO HEALTH SHARING

"Contribute" or "Contribution" – The dollar amounts voluntarily transferred by a Member to Impact Health Sharing for continued participation in the ShareRight program. Because participation in the ShareRight program is not a contract for insurance and participation is voluntary, contributions are not a "demand for payment" for a product or service.

"Invoice" or "Statement" – A demand for payment for medical care services rendered, submitted by a medical care provider to a Member.

"Pay" or "Payment" – The dollar amounts tendered to a medical care provider or facility by Impact Health Sharing and/or a Member under the ShareRight program in consideration for a medical care service rendered by the provider to a Member under the provider's contract for service.

"Share" or "Sharing" – The joint sharing of certain medical expenses incurred by a Member that is contributed to by other Members of the ShareRight sharing community.

"Share Notice" or "Notice" – A notification of voluntary contribution amounts due under the ShareRight program submitted by Impact Health Sharing to a Member. Share Notices are typically delivered monthly as a "Monthly Share Notice."

SHARERIGHT PROGRAM & MEMBERSHIP

Bill Approved for Sharing – An Eligible Medical Bill that meets the criteria for sharing in the Guidelines and meets the other conditions for sharing, including whether the Member Household's PRA has been met and other sharing limits have not been exceeded.

Cancellation Date – The month and day membership ends due to the Member's withdrawal or an administrative cancellation.

Effective Date – The date the Member's current PRA has begun.

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

Eligible Medical Bill – An incurred medical bill that meets the criteria for sharing as established in the Guidelines, the Eligible Medical Bill may be reduced by any discounts, fees, or other sources of payment.

Illegal Drugs – Any "controlled substance" or "dangerous drug" that has not been legally prescribed and/or dispensed, or the use of a prescription drug that is not in accordance with the manner in which it was prescribed.

Member – Any Member of the ShareRight program, including each family member participating in a Member Household.

Member Household – The related family members participating in the ShareRight program.

Membership Date – The date a Member's participation in the ShareRight program begins. Medical bills incurred after this date may be considered for sharing among Members.

Medical Emergency – For the purposes of sharing, a medical emergency is defined as:

- A sudden and unforeseen illness, injury, or condition that requires immediate medical attention to prevent:
  - Serious jeopardy to the life or long-term health of the Member,
  - Serious impairment to bodily functions, or
  - Serious dysfunction of any bodily organ or part.

Pre-existing – Any diagnosis, testing, medication, or treatment of a condition that a Member has received before their initial effective date with ShareRight.

Primary Member – An adult member who is the main contact for the household membership.

Primary Responsibility Amount (PRA) – The dollar amount a Member Household must pay toward their own Eligible Medical Bills during a 12-month period before their Eligible Medical Bills can be published and shared by the Membership. The PRA 12-month period begins on the Membership Date.

Provider Fee – The portion of a medical bill that a Member pays to a healthcare provider at each visit.

SHARE ACCOUNT ACTIVATION

Auto-Share (Recurring EFT) – a Sharing Permission enabling a Primary Member to set up recurring electronic funds transfers (EFTs) to transfer the Total Share Amount Due specified in their Monthly Share Notice.

External Account – an existing bank account that is linked to the Primary Member's Share Account and is used to transfer via EFT the Total Share Amount Due into the Share Account each month.

Manual Share – a function that enables a Primary Member to initiate an "on-demand" EFT to transfer the Total Share Amount Due specified in their Monthly Share Notice.

Permissions – are auto-enable functions (e.g., Auto-Share) that are set and managed by the Primary Member.

Share Account – the Member-controlled virtual account that is linked to both your External Account and your deposit account at America's Christian Credit Union and is used for all sharing transactions and activities.

MONTHLY SHARE NOTICE

Grace Period – the number of days between the Share Due Date and Past Due Date.

Monthly Share Amount – the sum of the Share Portion and Required Miscellaneous Portions published in the Share Notice.

Due Date – the day of the month that a delinquent Total Share Amount Due becomes past due.

Past Due Reminders – Share Notice Reminders sent to Members who have not paid their Share Notice and are past due.

Payment Reminders – Share Notice Reminders are sent only to Members who pay manually instead of automatically and only if the Total Share Amount Due has not yet been paid.

Previous Balance – is the sum of any past due, unpaid amounts published in the Share Notice.

Required Miscellaneous Portion – an amount set by Impact Health Sharing to fund certain described activities, such as its administrative and program expenses.

Share Due Date – the day of the month by which the Total Share Amount Due must be transferred via EFT in full.

Share Notice – the written notification to a Member that details the Total Share Amount Due for the month.

Share Notice Date – similar to a statement date or invoice date, it is the day of the month that the Share Notice is published and distributed.

Share Payment (Funding) – transferring funds (Total Share Amount Due) from a Member's External Account to their Share Account.

Share Portion – the portion of the Monthly Share Amount that is collected and used specifically for Member-to-Member sharing of Eligible Medical Bills.

Total Share Amount Due – the sum of the Monthly Share Contribution Amount (Share Portion and Required Miscellaneous Portion), Optional Portion (auto-enabled by the Member), Service Fee, and any past due amount (Previous Balance).

MEDICAL BILLS & NEEDS

Adjusted Amount – the discounted or repriced amount.

Approved for Sharing – the portion of the Adjusted Amount that is Eligible for Sharing as per the Guidelines.

Bill Status – the processing stage/state of a specific Need or Bill.

Charge Amount – the gross amount billed by the Medical Provider.

Explanation of Sharing (EOS) – is a notice sent to a Member detailing the eligibility status of a bill, any discounted amounts, what portion of the remaining Charge Amount has been shared by the membership, and any remaining amount that must be paid by the Member.

Member Responsibility – the portion of the Adjusted Amount calculated to be the Member's responsibility and will not be shared.

Need – is a grouping of medical bills by a medical event such as knee surgery. Individual medical bills may sometimes be referred to as a "Need."

Published Amount – the portion of the Adjusted Amount that is Eligible for Sharing and has been published/allocated to the membership for sharing.

Received Date – the date that Impact Health Sharing receives the medical bill and begins processing the bill for eligibility.

Service Date – the date that the Member (patient) received services from the Medical Provider.

Shared Amount – the Published Amount that has been shared and collected in the Member's Share Account.

MATCHING & SHARING

Sharing (Member-to-Member Transfers) – moving funds from a sending Member's Share Account to a receiving Member's Virtual Bill Account.

SHARE ACCOUNT

Available Balance – the total sum that is available for sharing a new Eligible Medical Bill and/or Withdrawal. It is the Total Balance minus the Pending Balance minus the Restricted Balance.

Debits & Sharing – The "Negative (-)" transactions debited out of the Member's Share Account, which would be Required Miscellaneous Portion (i.e., Debits), Optional Portion, and Share Portion.

Deposits & Credits – The "Positive (+)" transactions that are credited to the Member's Share Account, such as EFTs (i.e., Deposits) and Shared Funds Received (i.e., Credits) that a Member might receive to pay their Eligible Medical Bill.

Pending Balance – the sum of EFT(s) that have been initiated but have not yet posted to the Member's Share Account.

Restricted Balance – the sum of funds that have been credited to the Member's Share Account for the purpose of paying an Eligible Medical Bill.

Total Balance – the sum of the Pending Balance, Restricted Balance, and Available Balance in a Member's Share Account.

STATE DISCLOSURES

Access Full State Disclosures Here **[ShareRight disclosures page, to come]**