TOR Health Employee Membership Guidelines

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1. About these guidelines

These are the Membership Guidelines for the **TOR Health Employee Membership**, a voluntary medical cost-sharing membership operated by ClearBook Health and offered to employees of participating employers and their households.

TOR Health is not insurance. It is a community of members who voluntarily share one another's eligible medical expenses, operated by ClearBook Health, a Texas nonprofit that is not an insurance company. In these guidelines, "TOR Health" includes ClearBook Health acting as its operator. TOR Health membership does not guarantee that any medical bill will be paid. Each member remains responsible for their own medical bills. Wherever these guidelines say TOR Health pays, shares, reimburses or will do something with sharing funds, it means TOR Health facilitates voluntary sharing of members' contributions, subject to available shares and proration (Section 5). Nothing in these guidelines is a promise to pay. Notices required by state law appear in Section 12.

How the pieces fit together.

- **The TOR Health Employee Membership (these guidelines)** is member-paid and voluntary. Joining is solely the employee's decision.
- **Approved DPC Providers** are direct primary care (DPC) organizations that partner with TOR Health. Each provides members' primary care and either provides care navigation or arranges it through a TOR Health-approved care navigation organization. For every adult member, holding an active membership with an Approved DPC Provider is a condition of sharing (Section 3).

Our approach to buying care. TOR Health is built on buying medical care directly, at fair cash prices. Care is more affordable when members and their care teams can find good providers, know the price in advance and choose where care is delivered. Care navigation helps members find providers, compare options, get prices and schedule care. This is how we act as careful stewards of what fellow members entrust to us: money not spent on unnecessary costs is available for members facing serious Needs.

Members coordinate non-emergency care with their care navigation team before the service (Sections 4.4 and 5). Emergency care should never be delayed to get a price or approval.

The employer's role. The TOR Health Employee Membership is not an employee welfare benefit plan, an employer-sponsored health plan or a multiple employer welfare arrangement (MEWA). A participating employer does not sponsor, endorse, fund or administer the membership, and does not contribute to members' shares. The employer's only role is to let TOR Health make information about the membership available to its employees, including through an introduction by an Approved DPC Provider, and, as a convenience to members, to deduct the shares each member chooses to pay from that member's after-tax pay and send them to TOR Health (a list bill). The deduction is never pre-tax and is not made through a Section 125 cafeteria plan. The employer makes no sharing decisions, has no role in eligibility or the member attestation, and receives no payment or compensation of any kind from TOR Health. Neither the employer nor any health plan it sponsors receives any information about a

member's health, care navigation, Needs or sharing from TOR Health or any of its partners. The same applies to payment card information, including where, when and for how much a TOR Health payment card was used.

Key terms.

Term	Meaning
Member	Each person enrolled in a household's membership
Household	The employee and any spouse and dependents enrolled under the same membership
Shares	The monthly amount a household contributes to take part in sharing
Need	One or more medical bills tied to a single accident or illness
IUA (Initial Unshareable Amount)	The portion of each Need the household pays before sharing begins
Start Date	The first day a member's sharing eligibility begins
Membership year	The 12 months beginning on the employee's Start Date, and each 12 months after that
Application Date	The date the member's enrollment was submitted
Date of service	The date a provider delivered the care on a bill. Each bill is judged on its own date of service
Approved DPC Provider	A direct primary care organization that meets the requirements in Section 3.3 and has an agreement with TOR Health
Care navigation	The service that helps members find, price and schedule care, provided by the Approved DPC Provider directly or through a TOR Health-approved care navigation organization the provider arranges
Specialist visit	An office, clinic or telehealth visit with a licensed physician, nurse practitioner or physician assistant practicing in a specialty other than primary care, to evaluate or manage a health problem. It includes simple tests done during the visit. It does not include imaging, outside lab work, procedures, surgery, therapy, or hospital or facility charges
Coordinated care	Care the member arranged with care navigation before the service. Coordinating care is how members pre-notify TOR Health (Section 4.4)
Medical emergency	A sudden illness, injury or condition, including a complication of pregnancy, with symptoms severe enough that a reasonable person with average knowledge of health would expect that not getting immediate care could seriously endanger the person's life or health, seriously impair a bodily function, or cause serious harm to an organ or body part
Medically necessary	Care from a licensed provider that is appropriate in type, frequency, setting and length to diagnose or treat the member's illness or injury; consistent with generally accepted standards of medical practice; not mainly for the convenience of the member or provider; and no more costly than an alternative that is as likely to produce the same result. A drug must be FDA-approved, or used off-label in a way supported by standard drug references or published clinical evidence. Being

Term	Meaning
	ordered by a provider does not by itself make care medically necessary
Experimental or investigational	A drug, device, treatment or procedure that is not approved by the FDA for its intended use, is under study in a clinical trial, or is not generally accepted as standard medical practice
Gene therapy and cell therapy	Gene therapy is a treatment that adds, replaces, inactivates or edits a gene in a person's cells, inside or outside the body, to treat or prevent disease, such as gene therapies for spinal muscular atrophy, hemophilia or sickle cell disease. Cell therapy is a treatment that gives a person living cells that were collected, grown, modified or engineered outside the body, such as CAR-T cell therapy. Neither includes blood transfusions or standard bone marrow or blood stem cell transplants, which are shared under the transplant rules (Section 9.3)
Reasonable price	The lowest of the price agreed through care navigation, an available cash price, or 300% of the Medicare rate for the service. Higher amounts are shared only for a clinically justified exception approved by the board. Where Medicare has no comparable rate, TOR Health uses a benchmark, such as a percentage of the Medicare rate for a comparable service, the average sales price for a drug, or a national price database, and tells the member in its determination which benchmark it used. A provider's own posted price is not the benchmark. Members may be responsible for charges above the shareable amount
Preventive service	A service listed in Section 6 and delivered as a screening or preventive service to a member without signs or symptoms of the condition being screened
Pre-existing condition	Defined in Section 7.1
Lapse	Any gap in a member's sharing membership or, for an adult, Approved DPC membership that is not cured within the 30-day grace period (Section 3.7)
Life change event	An event listed in Section 3.5 that allows a household to change its membership outside its membership anniversary
Dependent	An unmarried child under 26 of the employee or spouse, including stepchildren, adopted children, children placed for adoption and children under legal guardianship, and a dependent over 26 who qualifies under Section 3.6
Eligible employee	An employee who receives W-2 wages from a participating employer and meets these guidelines. TOR Health, not the employer, decides eligibility
List bill	The employer's after-tax payroll deduction of each member's shares, sent to TOR Health under the member's payroll deduction authorization (Section 4.1)
Payroll deduction authorization	The member's electronically signed, revocable authorization for the employer to deduct shares from the member's after-tax pay (Section 3.4)
Membership anniversary	The first day of each membership year after the first
IUA credit	Amounts paid toward the IUA of each open Need, and the number of IUAs met in the current membership year. IUA credit carries over only with continuous membership (Section 3.7)

2. Statement of shared faith and ethical beliefs

2.1 Who we are

TOR Health is a faith-based, not-for-profit medical cost sharing community operated by ClearBook Health, a Texas nonprofit. We exist to put into practice the enduring religious and ethical teachings that command us to love our neighbors and to bear one another's burdens. We acknowledge accountability to a higher power in all that we do. We welcome people of all faiths whose faith traditions embrace the common belief that we are called to care for one another and help bear one another's burdens in times of need, and who sincerely share and attest to the beliefs set out below.

Our community is built on the Golden Rule, "do unto others as you would have them do unto you," a teaching shared across many faiths and belief systems, from the words of Christ in Matthew 7:12 and the wisdom of Hillel to parallel teachings in traditions around the world. We believe that when people who hold this teaching in common join together voluntarily, they can care for one another's health needs directly, personally and faithfully.

TOR Health limits membership to those who sincerely share these beliefs, as shown by each adult member's signed attestation at enrollment, which members reconfirm each time they submit a Need. TOR Health membership is not insurance, and ClearBook Health is not an insurance company.

2.2 Statement of shared beliefs

At the core of what we do, and how we relate to one another as a community, is this set of common beliefs. Every TOR Health member holds and lives by them:

1. We believe in, and hold ourselves accountable to, a higher power, and we believe that caring for those in need is an expression of that accountability. We welcome members of every faith who share these beliefs.
2. We believe in the Golden Rule, that we must treat others as we would want to be treated, and that this shared religious and ethical teaching obligates us to help our fellow members in times of medical need.
3. We believe it is our moral and religious duty to voluntarily share in one another's eligible medical burdens, according to these guidelines and as our collective resources allow.
4. We believe our bodies are entrusted to us, and that we owe our fellow members an ethical duty to maintain a healthy lifestyle; to avoid foods, substances, behaviors and habits that cause sickness or disease; and to abstain from the use of illegal drugs and the abuse of alcohol or prescription medications.
5. We believe we owe one another a duty to make legal, mature and responsible decisions that do not create unnecessary risk of injury to ourselves or others.
6. We believe that faithful stewardship of our health includes an ongoing, personal relationship with a primary care physician, and that regular, direct primary care is the foundation of wise and preventive use of our community's shared resources.
7. We believe we are stewards of resources given in trust by our fellow members, and that each of us must act with honesty, integrity and cost-conscious care whenever we ask the community to share a Need.
8. We believe every member has a right of conscience to direct his or her own health care, in consultation with physicians, family and other trusted advisors.

9. We believe we have a fundamental right, guaranteed under the United States Constitution, to associate voluntarily in the lawful exercise of these common beliefs and to share one another's health care expenses directly.

2.3 Member attestation

At enrollment, every adult member signs the following on behalf of themselves and every member of their household. A member who turns 18 signs it within 30 days of their birthday, and an adult added to the household signs it before that change takes effect:

1. **Sincerity of belief.** I have read the Statement of Shared Beliefs. I sincerely hold these beliefs, I will strive to live by them, and I understand that TOR Health limits membership to those who share them. If I cease to hold these beliefs, I will notify TOR Health, and I understand my membership will end.
2. **Not insurance; no guarantee.** I understand that neither TOR Health nor ClearBook Health, which operates it, is an insurance company, that my membership is not an insurance policy, and that neither TOR Health nor any member guarantees or promises payment of my medical bills. I remain personally responsible at all times for my own medical bills.
3. **Voluntary sharing.** I understand that all monthly contributions are voluntary gifts, that sharing of any Need is voluntary and governed by these guidelines, and that membership creates no legally enforceable right to have any medical expense shared.
4. **Direct primary care.** I will establish and maintain an active membership with an Approved DPC Provider for every adult in my household as a condition of TOR Health membership, and I understand that this relationship is how our community lives out its belief in proactive, preventive and faithful stewardship of health.
5. **Healthy living.** I will practice good health measures and pursue a balanced lifestyle. I will abstain from illegal drugs, will not abuse alcohol or prescription medications, and will truthfully disclose tobacco or vaping use, which carries an increased monthly contribution and, for members 50 and older, sharing limits under these guidelines.
6. **Honesty and cooperation.** I will act with honor and integrity in every dealing with this community. I will submit only truthful sharing requests, cooperate fully in the review of my Needs, including providing records and signing releases, and I understand that fraud or deception may result in termination of my household's membership (Section 3.10).
7. **Dispute resolution.** For any dispute with TOR Health or its affiliates, I agree to first submit to good-faith mediation and, if unresolved, to binding arbitration, as described in Section 11.4.
8. **Reconfirmation.** I will reconfirm these beliefs each time I submit a Need, and I understand that my continued membership depends on it.

The Georgia and Texas notices in Sections 12.2 and 12.3 appear in full beneath the signature block of the attestation form.

The attestation is between each member and TOR Health. The employer has no role in it, does not see it, and does not ask about or discuss any member's beliefs.

3. Eligibility and membership

3.1 Who may join

The TOR Health Employee Membership is open to employees of a participating employer, and to the employee's spouse and dependent children. Spouses and children may join only together with the employee and cannot hold this membership without the employee. If the employee's membership ends, the membership of the employee's spouse and children ends on the same date. TOR Health, not the employer, decides who is eligible. An employer whose only employees are its owners and their spouses is not a participating employer. Each member's primary residence, where they live for most of the year, must be in a state where TOR Health offers the Employee Membership, currently Georgia and Texas. A dependent child who lives outside that state temporarily for school, or with their other parent under a custody arrangement, remains eligible.

3.2 Membership tiers

Tier	Who is included
Employee Only	The employee
Employee + Spouse	The employee and spouse
Employee + Children	The employee and dependents (Key terms)
Employee + Family	The employee, spouse and dependents (Key terms)

3.3 Approved DPC membership required

Every adult member of the household (age 18 and over) must hold an active membership with an Approved DPC Provider to be eligible for sharing. The membership itself is the requirement; a member need not be on a particular doctor's panel. The membership must be with an Approved DPC Provider, but a member may obtain it through any source, such as paying for it personally or through a separate health plan. TOR Health has no role in, and is not part of, any health plan that provides a DPC membership.

Children enrolled in the Employee + Children or Employee + Family tier are included in the household's Approved DPC Provider membership, which provides access to primary care services consistent with the provider's scope of practice and capabilities. Families may use those services for pediatric care, when available, or may use the child's own pediatrician. A child who turns 18 must hold a DPC membership by the household's next membership anniversary to remain eligible for sharing.

First DPC visit. Each adult member must complete a first visit with their Approved DPC Provider, in person or by video, within 120 days after their Start Date, or, for a member who turns 18, within 120 days after their DPC membership starts. The visit establishes care and reviews the member's history, medications, preventive care and health risks. If an adult has not had this visit in time, the member pays more of the first non-emergency Need they open afterward whose eligible bills exceed its IUA: after any IUA, the member pays the next $2,500 of that Need's eligible cost, or all of the remaining cost if it is less, and the rest is considered for sharing. This applies only once. It is never added to the $2,500 for non-coordinated care (Section 4.4). When both would apply to the same Need, the member pays no more than $2,500 in total for the two together, or all of the remaining eligible cost if it is less, and this first-visit amount is then used up. A member who completes the visit late no longer owes this amount on any Need opened after the visit.

TOR Health partners with DPC organizations committed to proactive, accessible, relationship-based primary care. Approved DPC Providers engage members in their health, emphasize prevention and healthy choices, identify and manage health risks and chronic disease early, and help members live longer, healthier and more fulfilling lives.

TOR Health approves a DPC organization as an Approved DPC Provider when, under a written agreement with TOR Health, it:

- provides primary care for a flat periodic fee, with no per-visit charges brought to sharing;
- delivers the preventive services in Section 6 that fall within primary care;
- provides care navigation for every household member, including children, or arranges it through a TOR Health-approved care navigation organization, and remains accountable for that access: finding providers, obtaining cash prices and estimates, scheduling care, opening Needs and coordinating care;
- offers members after-hours access to a clinician by phone, text or telemedicine;
- shares the records needed for Need and pre-existing condition determinations, with the member's authorization;
- bills services outside its membership fee to sharing only at the reasonable price, and TOR Health, not the DPC, decides whether they are shared;
- notifies TOR Health and the member before ending an adult member's DPC membership, so the member can restore it within the 30-day grace period (Section 3.7);
- keeps TOR Health member information, including care navigation, separate from any information it holds for an employer or an employer's health plan, and does not share it with them, directly or through a care navigation organization; and
- confirms each member's membership status to TOR Health at least monthly.

TOR Health publishes the current list of Approved DPC Providers. The TOR Health board, which is the board of directors of ClearBook Health, reviews all existing and potential DPC partnerships periodically and decides, in its sole discretion, whether to approve, continue or end each one. If a provider stops being an Approved DPC Provider, TOR Health will notify affected members at least 120 days in advance, and they may move to another Approved DPC Provider within that time without a lapse.

An adult member whose DPC membership ends is not eligible for sharing for dates of service after it ends. A gap in DPC membership is treated as a lapse (Section 3.7). A member may move from one Approved DPC Provider to another without a lapse if there is no gap between the two memberships.

3.4 Enrollment

- An eligible employee may enroll in any month. The Start Date is the first day of the month after the Application Date. If the enrollment is received after the 20th of the month, the member pays the first month's shares directly to TOR Health (Section 4.1).
- There are no health questions at enrollment except one question about current pregnancy and one about tobacco and vaping use (Section 4.1).
- Each adult member signs the member attestation in Section 2.3 and also acknowledges that they have read these guidelines, understand the pre-existing condition limits, authorize bill negotiation and the release of medical and billing records needed to review Needs (Section 3.10), and understand that the guidelines may change and that continued payment is acceptance of the current guidelines, and agree to the collection and sharing of member information described in Section 11.6.

- Each employee confirms that they have received the TOR Health Employee Notice and, to pay through the list bill, signs a payroll deduction authorization. The authorization is after-tax, is not a Section 125 deduction and may be revoked at any time (Section 4.1).
- The Application Date is recorded for every member and is used in Section 7.

Medical Release Authorization (MRA). The MRA lets TOR Health, its Approved DPC Providers and their care navigation teams talk with providers, obtain medical and billing records, coordinate care, get prices and negotiate bills. Members sign the MRA by click-through each time they submit a Need, and a parent or guardian signs for a minor. A member may revoke the MRA in writing, but TOR Health may then be unable to review and share that member's Needs.

3.5 Adding and removing members

- Family members may be added when the household enrolls, on the household's membership anniversary, or after a life change event (below). A newborn added within 30 days of birth is a member from the date of birth. A child adopted or placed for adoption may be added within 30 days of the adoption or placement, with membership starting on the first day of the month after the request is received; it is not backdated. Adoption or placement documentation is required.
- Except for newborns (above), membership changes and terminations take effect on the first day of a month.
- **Cancellation.** A household may cancel its membership at any time by notifying TOR Health. The membership ends on the last day of the month in which TOR Health receives the request.

Life change events. A household may also change its membership within 30 days of any of these events. Except for newborns and adoptions (above), the change takes effect on the first day of the month after TOR Health receives the request, and documentation of the event may be required.

Event	What the household can do
Marriage	Add the new spouse and any of the spouse's dependent children
Divorce or legal separation	Remove the former spouse. The former spouse may move to the TOR Health Individual Membership with no gap
Death of the employee	The surviving spouse and children may move to the TOR Health Individual Membership with no gap
Death of a spouse or dependent	Remove the household member and change tier
Dependent turning 26	The dependent leaves the household membership (Section 3.6) and may move to the Individual Membership with no gap
Dependent marries	The dependent leaves the household membership (Section 3.6) and may move to the Individual Membership with no gap
Employee leaves the participating employer or loses eligibility	The Employee Membership ends at the end of that month. The employee and household may move to the Individual Membership with no gap
Employee moves to another participating employer	Membership continues with no gap and no change to accumulated time. The employee signs a new payroll deduction authorization for the new employer and pays TOR Health directly for any month before appearing on that employer's list bill
Employee revokes the payroll deduction authorization while	Membership continues with no gap and no change to accumulated time. The household pays its shares directly to TOR Health (Section

Event	What the household can do
still employed	4.1)
A family member loses other health coverage	Add the family member
A family member moves to Georgia or Texas	Add the family member
A member moves between Georgia and Texas	Membership continues with no gap and no change to accumulated time
Gaining custody of a child	Add the child

A member who moves to the Individual Membership with no gap keeps their pre-existing condition time and IUA credit. Each move to the Individual Membership described above is available only where TOR Health offers it, currently Georgia and Texas, and only to members who meet its eligibility rules, with no exceptions: a member must be under age 65 and must not have regularly used a tobacco product, as defined in Section 4.1, in the 12 months before applying. A member of the Individual Membership who becomes an eligible employee of a participating employer may move to the Employee Membership with no gap. A member who moves with no gap in either direction keeps their Start Date, Application Date and IUA credit, does not repeat the first DPC visit (Section 3.3), and their open Needs keep the IUA they started with. A pregnancy that is shareable as maternity on the day of a no-gap move to the Individual Membership stays shareable on the same terms. The Individual Membership guidelines describe how to move.

3.6 Dependents reaching age 26 or marrying

A dependent's eligibility under the household membership ends at the end of the month in which they turn 26 or marry, whichever comes first. TOR Health will notify the household in advance of a dependent's 26th birthday. The household must tell TOR Health within 30 days of a dependent's marriage. The dependent may move to the TOR Health Individual Membership with no gap, if they meet its eligibility rules (Section 3.5), and keep their pre-existing condition time and IUA credit.

Dependents with a disability. A dependent may stay on the household membership after turning 26 if they are unmarried, cannot support themselves through work because of a physical or mental disability that began before age 26, and they depend mainly on the employee for support. The household must send a physician's certification of the disability within 30 days of the dependent's 26th birthday, and again each year when TOR Health asks.

3.7 Continuous membership and lapse

A member keeps their accumulated time and IUA credit only with continuous membership in **both** the sharing membership and, for adults, an Approved DPC Provider. A lapse in either:

- restarts the member's pre-existing condition look-back and phase-in from the new Start Date, and
- cancels all IUA credit previously met.

Moving between the TOR Health Employee and Individual Memberships with no gap is not a lapse.

30-day grace period. If a membership ends for any reason other than misuse of trust or conduct (Section 3.10), including a missed share payment or the household's own cancellation, the household

may re-enroll within 30 days of the end date by paying any missed shares, as long as the employee is still eligible. A membership that ends for unpaid shares ends on the last day of the last month for which shares were paid, and the 30 days run from that date. If the employer does not send a month's list bill shares by the 15th of that month, the member may pay that month's shares directly to TOR Health within 30 days after the 15th, and the membership is treated as continuous. An employer's failure to send shares does not by itself end a membership. An adult whose DPC membership also ended must restore it with their Approved DPC Provider within the same 30 days, with no gap in the provider's records. When both are done, the membership is treated as continuous: pre-existing condition time and IUA credit carry on, and bills with dates of service in the gap are considered only if the household asked to re-enroll before the first such date of service, or the care was an emergency. The household's tier and IUA level stay the same as before the gap. If only an adult's Approved DPC membership ends, the same rule applies: the member restores it within 30 days with no gap in the provider's records, and the membership is treated as continuous. That member's bills with dates of service in the gap are considered only if the member asked to restore the DPC membership before the first such date of service, or the care was an emergency.

If the household does not re-enroll, or the DPC membership is not restored, within 30 days, there is no grace period. A later re-enrollment is treated as a new enrollment: the member's IUA credit is cancelled and their pre-existing condition look-back and phase-in restart from the new Start Date. A household whose membership was ended for misuse of trust or conduct is always treated as a new enrollment if it is allowed to re-enroll.

3.8 Eligibility on the date of service

A bill is eligible only if, on that bill's date of service, the member was active in the sharing membership with shares paid and, for an adult, held an active Approved DPC membership. A member who turns 18 has until the household's next membership anniversary to obtain one (Section 3.3). For a member who pays through the list bill, a month's shares are treated as paid from the first day of that month if the employer sends them by the 15th of the month, or if the member pays them directly within the period in Section 3.7.

3.9 Members age 65 and older

A member age 65 or older must be enrolled in Original Medicare Parts A and B to remain eligible. Medicare Advantage (Part C) plans do not meet this requirement. If a member turning 65 does not enroll, their membership ends at the end of the month in which they turn 65. For members 65 and older, sharing is secondary to Medicare: the member submits the Medicare Summary Notice or Explanation of Benefits, and TOR Health considers only eligible amounts Medicare did not pay. Services Medicare does not cover are considered under these guidelines as usual.

3.10 Member conduct, cooperation and termination

Sharing works only when members can trust one another. Every adult member agrees to the following on behalf of their household.

Honesty and misuse of trust. Members give complete and truthful information at enrollment and with every Need. Misuse of trust includes:

- submitting a falsified, altered or inflated bill, receipt or estimate;

- knowingly hiding a member's tobacco use, by a false answer at enrollment or by not reporting it within 30 days (Section 4.1);
- hiding or misstating medical history, the cause of an injury, or another payer that may be responsible;
- using shared funds, or a payment card loaded for a Need, for anything other than paying the provider for the care that was shared;
- keeping a refund or credit of shared money instead of returning it to TOR Health; and
- helping another member do any of these.

If TOR Health finds misuse of trust, it may deny the Need, recover any amounts already shared, and end the household's membership. Amounts charged on a TOR Health payment card are recovered only by offset against later sharing (Section 5). It may also report fraud to the appropriate authorities.

Records and cooperation. Each adult member authorizes TOR Health, its Approved DPC Providers and its agents to obtain the medical, billing and payment records needed to review a Need, decide pre-existing status, negotiate bills or recover amounts from other payers. Members sign any authorization requested, and parents or guardians do so for minor members. Members also respond to requests for information and contact providers who do not respond. If a member does not provide requested information within 6 months, TOR Health may close the Need as not shareable.

Respectful conduct. Members do not use threatening, harassing or abusive language or behavior toward TOR Health staff, care navigation teams, providers or other members, including threats of harm. TOR Health will give a written warning first, except for threats of violence, and may end the membership if the behavior continues.

When TOR Health may end a membership. A membership ends, at the end of the month, when:

- shares are unpaid, in which case the membership ends on the last day of the last paid month, subject to the 30-day grace period and to the member's right to pay directly when the employer does not send list bill shares (Section 3.7);
- an adult member's Approved DPC membership ends and is not restored within the 30-day grace period, except for a member who turned 18 and is within the time allowed in Section 3.3;
- the member is no longer eligible, such as a dependent turning 26 or marrying, an employee leaving a participating employer, or a member 65 or older not enrolled in Medicare;
- the member's primary residence moves to a state where the membership is not offered, except a dependent child living away temporarily for school or with their other parent under a custody arrangement (Section 3.1). The household tells TOR Health within 30 days of the move, and the member's membership ends on the last day of the month of the move;
- an adult member no longer holds the Statement of Shared Beliefs (Section 2.2);
- TOR Health finds misuse of trust; or
- abusive behavior continues after a warning.

TOR Health may also end a membership when a member declines coordinated care, including a requested second opinion, on three separate Needs.

TOR Health gives written notice of any termination, and the member may appeal under Section 11.3. Eligible bills with dates of service before the termination date are still considered, except bills tied to misuse of trust. A household whose membership was ended for misuse of trust or conduct may be refused re-enrollment.

4. Monthly shares and the IUA

4.1 Monthly shares

Each household pays a monthly share set by tier and IUA level. Shares are collected through the employer's list bill by after-tax payroll deduction under the member's payroll deduction authorization, in a single deduction from the first paycheck of each month. The deduction is never pre-tax and is not made through a Section 125 cafeteria plan. The member pays TOR Health directly: (a) for the first month, when the enrollment is received after the 20th of the month; (b) for any month in which that paycheck cannot cover the full share; (c) for every month after the member revokes the payroll deduction authorization while still employed, which the member may do at any time and which does not end the membership; (d) for any month before the member first appears on a new participating employer's list bill; and (e) for any month the employer does not send, as described in Section 3.7. Share amounts are generally set once a year. TOR Health may change them at another time with at least 60 days' notice to members.

Tobacco contribution. A household with one or more tobacco users pays an additional **$75 per month**. A tobacco user is a member who, at any time in the 12 months before their Application Date or during membership, regularly used a tobacco product. Tobacco products are cigarettes, cigars, pipes, smokeless or dipping tobacco (including snus and any pouch that contains tobacco), heated tobacco products, and e-cigarettes and other vaping products, with or without nicotine; in these guidelines, tobacco use includes vaping. Tobacco-free nicotine pouches, such as Zyn, and nicotine replacement products, such as patches, gum and lozenges, are not tobacco products, and the occasional celebratory cigar or pipe does not count. Members disclose tobacco use at enrollment and must tell TOR Health within 30 days if they start using a tobacco product during membership. The additional contribution ends on the first of the month after TOR Health receives proof of cessation for every tobacco user in the household (Section 10.1). Knowingly hiding a member's tobacco use, by a false answer at enrollment or by not reporting it within 30 days, is misuse of trust (Section 3.10).

Testing. If TOR Health has reason to believe that a member who uses nicotine pouches or nicotine replacement products also uses a tobacco product, it may ask the member to take a test that tells tobacco apart from other nicotine, such as an anabasine test, at TOR Health's cost. A member who does not take the test within 30 days is treated as a tobacco user from the date TOR Health asked until the member proves cessation.

Shares are divided when collected: the sharing portion is held in a dedicated account used only to share members' Needs, except for the new-member allocation described below, and the administrative portion funds operations. TOR Health tracks every sharing contribution member to member on a virtual ledger. Each member's sharing portion is allocated to specific eligible Needs of other members, and the ledger records which members' contributions helped pay each Need. Sharing funds belong to the members for sharing with one another; they are not the funds of TOR Health or ClearBook Health and, except for the new-member allocation below, are never used for administration.

New-member allocation. For each member's first 3 months of membership, TOR Health may use up to 85% of the sharing portion of that member's shares for program expenses and costs related to expanding the community. After the third month, the full sharing portion goes to sharing. The amount TOR Health actually uses is disclosed to members. Months in the TOR Health Individual Membership before a move with no gap count toward the 3 months. TOR Health does not pay commissions or compensation of any kind to brokers, agents, employers or anyone else for enrolling members.

4.2 IUA levels

The household chooses one IUA level: **$1,000, $1,500, $2,500 or $5,000**. A household may change its IUA level only on its membership anniversary. Needs and pregnancies that began before a change keep the IUA they started with: a Need begins with its first signs, symptoms or treatment, and a pregnancy at conception. Non-coordinated care costs the member an additional $2,500 per episode (Section 4.4).

4.3 How the IUA works

- The IUA applies **once per Need**, not once per year. A Need that continues past the membership year does not incur a second IUA.
- A household pays no more than **3 IUAs in a membership year**. After the third, every further eligible Need in that year is considered for sharing with no IUA. The $2,500 for non-coordinated care (Section 4.4) still applies and does not count as one of the 3.
- Preventive services in Section 6 have **no IUA**, except a service the Approved DPC Provider can perform that the member chooses to get elsewhere (Section 6).
- When the IUA for a Need is met, later eligible bills for that Need are considered for sharing with no further IUA, except as Section 4.4 provides for non-coordinated care.

4.4 Coordinated care and the IUA

Members coordinate every non-emergency service with their care navigation team before the service, so the right provider and setting can be found early. This includes specialist visits (Key terms), imaging, outside lab work, procedures, surgery, therapy and hospital care. Once a specialist referral is coordinated, later visits to the same specialist for the same Need are treated as coordinated. The following do not need to be coordinated: routine visits with the Approved DPC Provider, urgent care visits, visits with a child's own pediatrician, routine prenatal visits for a shareable pregnancy (Section 8), and emergencies.

Non-coordinated care. For each non-emergency service episode that was not coordinated, such as an admission, a surgery, a course of treatment, or care after an emergency was stabilized, the member pays the first $2,500 of that episode's eligible cost after any IUA that applies to it, or all of it if less, and the rest is considered for sharing. This applies at every IUA level, after the third IUA of the year, and to maternity care other than routine prenatal visits. It does not count as one of the 3 IUAs. This does not apply to the visits listed above or to emergencies. A member never pays more than a Need's eligible cost. TOR Health may waive the $2,500 when coordinating in advance was not reasonably possible, such as a fast referral to another provider within the same health system. After an emergency, members notify care navigation within 48 hours, or as soon as they are medically able. Once the member is stabilized, further care, including an admission, transfer or surgery, is coordinated with care navigation. Care after stabilization that was not coordinated, when coordination was reasonably possible, is non-coordinated care.

Required pre-notification. Advance care navigation and clinical review are required for planned inpatient admissions, surgery, cancer treatment, transplant services, high-cost specialty drugs and other designated high-cost care. When a member bypasses an appropriate lower-cost option, TOR Health may also limit sharing to the reasonable price of the coordinated option. Emergencies are exempt, and clinically necessary exceptions are available. Members pre-notify care navigation at least 7 days before planned care that requires pre-notification, or as soon as the care is scheduled if that is sooner. Expedited review is available case by case. Care that required pre-notification and was not pre-notified is non-coordinated care, and the $2,500 applies.

Second opinions. TOR Health may ask a member to get an expert second opinion, at no cost to the member, before sharing non-emergency surgery or other high-cost treatment, and the member agrees to complete it. The report goes to the member, their doctor and care navigation. The member and their doctor decide on the treatment. If a member declines a requested second opinion, the treatment it concerns is non-coordinated care, and the $2,500 applies. Declining coordinated care, including a requested second opinion, on three separate Needs may be grounds for ending the membership (Section 3.10). Emergencies are exempt.

5. How Needs are shared

1. **Start with care navigation.** The member contacts their care navigation team before scheduled care. Care navigation helps find a provider, get a cash price or estimate, and opens the Need.

2. **Coordinated care.** Coordinating care before the service is how members pre-notify TOR Health. Non-coordinated care costs the member an additional $2,500 per episode (Section 4.4). Emergencies are exempt, and TOR Health may waive the $2,500 as described in Section 4.4.

3. **Payment at the point of service.** For eligible scheduled care, TOR Health generally sends members' shared contributions directly to the provider through an approved digital payment method, after accounting for the IUA. When direct payment is unavailable or impractical, eligible expenses may be shared with the member by ACH or another approved method. TOR Health aims to complete sharing of eligible amounts within 30 days after it receives complete documentation, subject to available shares and proration. Members are encouraged to work with care navigation before making substantial payments. If a provider declines the digital payment card or asks for a deposit, TOR Health may share eligible amounts before the service, after accounting for the IUA. When the member coordinates or pre-notifies planned care (Section 4.4), the member tells care navigation whether the provider requires payment before the service. The member does this at least 7 days before scheduled care, or as soon as the care is scheduled if that is sooner. If the member does not, eligible amounts the member pays the provider are considered for sharing afterward. When a member pays a provider in advance to secure a discount, TOR Health shares the amount the member actually paid, up to the reasonable price. Prepaid packages or memberships covering multiple visits are shared only for visits actually received for a shareable Need, within any visit and dollar limits. Global maternity packages. When one provider charges a single price for prenatal care, delivery and postpartum care for a shareable pregnancy, and care navigation has coordinated it, the package is considered for sharing as part of the maternity Need. The member pays up to the maternity IUA toward the package, and the rest is considered for sharing on the provider's payment schedule; the maternity IUA is not applied again at delivery. If the delivery is a non-emergency Cesarean, the $7,500 maternity IUA applies, and the member pays the difference before more is shared. If the pregnancy ends in miscarriage, the standard IUA applies instead of the maternity IUA. If the pregnancy ends early or the member changes providers, sharing is limited to services received. Any refund is divided so that the member pays no more than the IUA that applies to the services received, and the rest is returned to TOR Health. If a provider refunds or credits any amount TOR Health shared, the member returns it to TOR Health within 30 days. A member should not present any insurance card for shared care.

4. **Emergencies.** Members seek emergency care without delay. Whenever reasonably possible, members avoid paying substantial charges at the time of service, so TOR Health can review and negotiate the bill and send members' shared contributions to the provider directly, including by

digital payment card. Eligible amounts a member has already paid are considered for sharing and may be shared with the member under these guidelines.

5. **Submit bills.** Members upload itemized bills, estimates and receipts through the member portal within **6 months** of the date of service. Bills submitted more than 6 months after the date of service are not shared unless delayed by circumstances beyond the member's control. For a bill under $1,000, a receipt and the member's attestation, given by click-through when the Need is submitted, are enough; TOR Health may still ask for an itemized bill. When submitting a Need, the member, or a parent or guardian for a minor, reconfirms the Statement of Shared Beliefs (Section 2) and signs the Medical Release Authorization (Section 3.4) by click-through.

6. **Determination.** The Approved DPC Provider gathers records and confirms an adult member's DPC membership is active; TOR Health makes every sharing determination.

7. **Negotiation.** TOR Health or its agent may negotiate any bill on the member's behalf. Sharing is limited to the reasonable price (Key terms), even when a member pays a provider's full billed charges. Members may be responsible for charges above the shareable amount. If a provider bills a member for charges above the reasonable price on care that was shared, the member forwards that balance bill to TOR Health within 30 days and does not pay the excess while it is disputed. TOR Health or its agent disputes those charges on the member's behalf. Non-coordinated care costs the member an additional $2,500 per episode (Section 4.4).

TOR Health payment cards. For eligible scheduled care, TOR Health may give a member a virtual payment card to pay a provider an approved amount. The card is TOR Health's payment method, funded with members' shared contributions. The member uses it only on TOR Health's behalf, only at the provider care navigation names, and only for the care and amount approved for that Need. Cards are issued only to adults; the card for a child's care goes to the employee or another adult member of the household. A card may be limited to one payment, one provider, a set amount and a short time, and TOR Health may cancel a card at any time. Members may add a card to a digital wallet, such as Apple Pay or Google Pay; the card's limits apply however it is used. Each card is delivered with, and displayed alongside, the statement described in Section 12.4. Cards are issued by a bank through TOR Health's payment card provider, and by using a card the member accepts the cardholder terms presented with it. A member owes nothing to ClearBook Health, the card bank or its partners for any charge on a card; ClearBook Health pays every charge. If a card is used for anything other than the approved payment, TOR Health treats the charge as a sharing payment the member was not eligible for and may offset it against later sharing for the household. Amounts offset this way do not count toward the IUA. Using a card for anything other than the approved payment is misuse of trust (Section 3.10). Members keep card details private and tell care navigation right away if a card may be lost, stolen or used without permission. When a card cannot be issued to a member, eligible amounts are shared by ACH or another approved method (item 3).

Rules for each Need.

- One Need may include many bills and many dates of service. Each bill is judged under the guidelines in effect on its own date of service.
- A recurrence of a condition becomes a new Need only after 12 consecutive months with no symptoms, treatment or medication for it.
- Related care and complications stay within the same Need. Unrelated conditions are separate Needs.

- Except in an emergency, treatment of an age-related degenerative condition of a joint or eye, such as a joint replacement or cataract surgery, is a separate Need for each joint or eye, with its own IUA, even when they share one diagnosis.
- Sharing is limited to the reasonable price (Key terms) for medically necessary care, and to $300,000 per Need, however long the Need continues. Sharing for any one member is also limited to $500,000 per membership year, across all Needs.
- TOR Health applies the IUA and any amount the member pays under Sections 3.3 and 4.4 first, then the limits in these guidelines, then the proportional share when another sharing organization shares the Need, and prorates last.

Proration. Sharing depends entirely on the shares members contribute. If the eligible Needs ready for sharing in a month are greater than the shares available, TOR Health may prorate: every Need shared that month is reduced by the same percentage. For example, if $300,000 of eligible Needs are ready and $240,000 of shares are available, each Need is shared at 80%. When shares later exceed Needs, TOR Health may use the surplus to share prorated amounts from earlier months. No Need is guaranteed to be shared in full.

Large Needs. Each month, 15% of the sharing portion of the shares received is set aside for very large Needs. No single Need may use more than one third of the shares available for sharing in any month.

Weekly Needs review. TOR Health reviews the community's Needs every week to see how these guidelines and its cost containment are working. The board approves any exception to these guidelines.

Other resources come first. Other medical coverage is primary to TOR Health sharing when it applies, including an employer or spouse's health plan, Medicare, Medicaid, TRICARE, workers' compensation, auto insurance, and homeowners or other liability insurance. Members must disclose and pursue these resources first, and TOR Health may share the remaining eligible costs under these guidelines. Fixed cash benefits, such as a lump-sum critical-illness payment, do not reduce sharing. Preventive services and preventive medications that the member can get at no cost through another health plan or program, including an employer's plan, are not shared (Section 6). If a member may qualify for a hospital or provider's charity care or financial assistance program, the member works with their Approved DPC Provider and TOR Health to apply. Amounts the provider forgives are not shared. A member who also belongs to another health care sharing organization must disclose it. TOR Health then shares only its proportional part of an eligible Need: one half if two organizations share the Need, one third if three, and so on. A member may not receive more than the eligible amount in total. Because TOR Health is not insurance, this rule does not create insurance coordination-of-benefits rights. If a Need may be the responsibility of one of these payers, including any injury at work, the member must submit the bills to that payer first and give TOR Health its payment or written denial before the Need is considered. Amounts another payer pays above the IUA are not shared. Only amounts the household pays, or another medical coverage pays under this section, count toward the IUA. If a provider waives or discounts the IUA, the shareable amount is reduced by the same amount. If the payer refuses to pay until a legal claim is resolved, TOR Health may wait to share, or share on condition that the member repays the community from any later recovery. Members agree to cooperate, disclose any third party that may be responsible, and assign to TOR Health their right to recover amounts the community has shared.

6. Preventive services

Every member may share the full set of preventive services recommended under the federal preventive care guidelines listed in Section 6.1, with **no IUA**, **no waiting period** and **no pre-existing condition limit**. The exceptions are contraception, HIV PrEP drugs and emergency contraception, which are not shared (Section 6.4). Preventive services and preventive medications are not shared when the member can get them at no cost through another health plan or program, including an employer's plan (Sections 5 and 9.1). Children's well-child visits and screenings are also not shared, except the newborn visit and childhood vaccines (Section 6.4). Much of this care is delivered inside the member's DPC membership at no extra charge. Members are expected to get preventive services through their Approved DPC Provider when those services are reasonably available there and clinically appropriate. When a recommended service is not available from that provider, or another provider or setting is medically appropriate, care navigation will help the member get it, and it is considered for sharing with no IUA. When the Approved DPC Provider can perform a preventive service and the member chooses to get it from another provider instead, the service is considered for sharing only as a regular Need, subject to the IUA. This does not apply to childhood vaccines, which may be given anywhere (Section 6.1).

6.1 What is included

Category	What it includes	Who
Adult screenings and counseling	Services rated A or B by the U.S. Preventive Services Task Force, such as blood pressure, cholesterol, diabetes, depression, cervical and lung cancer screening, and behavioral counseling	Adults as recommended
Colorectal cancer screening	Screening colonoscopy, including anesthesia, pathology and removal of polyps during the screen, and the follow-up colonoscopy after a positive stool-based test	Adults as recommended (currently 45–75)
Breast cancer screening	Screening mammograms, plus the follow-up imaging needed to complete the screen	Women as recommended
Immunizations	Vaccines on the schedules below (AAP for children, ACIP for adults), and their administration fee. Adult vaccines are given by the Approved DPC Provider when it offers that vaccine, and otherwise anywhere. Childhood vaccines may be given anywhere	All ages
Newborn care	The doctor visit within 48 hours of birth	Newborns
Women's preventive care	Services under the HRSA Women's Preventive Services Guidelines, including well-woman visits and prenatal screenings. Contraception follows Section 6.4	Women as recommended

Childhood vaccines follow the American Academy of Pediatrics (AAP) immunization schedule, and adult vaccines follow the CDC's Advisory Committee on Immunization Practices (ACIP) schedule. Recommendations and schedules apply as they stand on the date of service.

6.2 How to use it

Members should arrange preventive care through their care navigation team. Preventive services are considered for sharing with no IUA, except as Section 6 provides for a service the Approved DPC Provider can perform that the member chooses to get elsewhere. The visit itself stays preventive if it

becomes diagnostic. Tests and procedures added beyond the listed screening are a regular Need, except the follow-up services in Section 6.3.

6.3 Where preventive ends

Two follow-up services are considered for sharing with no IUA as part of completing a screen: diagnostic mammography or breast ultrasound after an abnormal screening mammogram, and a colonoscopy after a positive stool-based test (Section 6.1). Other follow-up care after an abnormal result, surveillance for a known condition, biopsies and treatment are not preventive. They are shared as a regular Need under Sections 4 and 7.

6.4 Not shared

- Contraceptive drugs, devices and procedures.
- Emergency contraception, in any form.
- HIV pre-exposure prophylaxis (PrEP) drugs.

Children's well-child care. Well-child visits and screenings under the HRSA Bright Futures guidelines are not shared. The newborn visit within 48 hours of birth and childhood vaccines (Section 6.1) remain shareable with no IUA. Care for a child's illness or injury is shared as a regular Need.

7. Pre-existing conditions

A pre-existing condition is not shared in a member's first 12 months, is shared up to $25,000 in total through month 24 and up to $50,000 in total through month 36, and is fully shareable from month 37, except as Section 7.2 provides for congenital and genetic conditions.

7.1 Definition

A **pre-existing condition** is any illness, injury or medical condition for which, in the **36 months** before the member's Start Date, the member had any of the following:

- signs or symptoms,
- a diagnosis,
- treatment, testing or a doctor's visit,
- a prescribed medication, or
- a doctor's suspicion, or symptoms the member noticed that would lead a reasonable person to seek care.

A condition with none of these in the 36 months before the Start Date is not pre-existing, even if the member had it earlier in life, except as Section 7.2 provides for congenital and genetic conditions.

Recurrent severe allergic reactions. Severe allergic reactions (hives, swelling, swollen airways, shock or anaphylaxis) that needed urgent or emergency care are a pre-existing condition if 2 or more happened in the 24 months before the Start Date, whatever the allergen.

7.2 Phase-in schedule

Months of continuous membership	Sharing for a pre-existing condition
1–12	Not shared

Months of continuous membership	Sharing for a pre-existing condition
13–24	Shared up to $25,000 in total
25–36	Shared up to $50,000 in total, including any amount shared in months 13–24
37 and after	Fully shareable, like any other condition

The dollar limits are per member and per pre-existing condition, and they are cumulative: no more than $25,000 is shared for the condition through month 24, and no more than $50,000 in total through month 36, including what was shared in months 13–24. Each bill falls under the limit for the period of its date of service. For example, if a pre-existing condition has $30,000 of bills in months 13–24, $25,000 is shared, and up to $25,000 more may be shared for bills in months 25–36. The IUA applies as normal to each Need. Months are counted from the Start Date and depend on continuous membership (Section 3.7). A pre-existing condition includes its related conditions, complications and recurrences, judged the same way as related care within a Need (Section 5).

Congenital and genetic conditions. A condition a member was born with, or a genetic condition, that was diagnosed or treated before the member's Start Date, or that is a pre-existing condition under Section 7.1, follows the phase-in schedule above but never becomes fully shareable: sharing for it is limited to $50,000 in total for as long as the member is a member, counting amounts shared under any TOR Health membership. A congenital or genetic condition that was not diagnosed or treated before the Start Date and is not a pre-existing condition under Section 7.1 is shared like any other condition. This rule does not apply to a newborn added from birth (Section 8). It also does not apply to a child adopted or placed for adoption before age 18 and added within 30 days, for congenital and genetic conditions the parents did not know about when the child was placed (Section 8). A genetic condition is a disease caused by an inherited or chromosomal abnormality, such as cystic fibrosis, sickle cell disease or hemophilia; having a gene or family history that raises the risk of a disease is not a genetic condition.

7.3 Application gap

A condition that first appears after the member's Application Date and within the 60 days before the Start Date is not treated as pre-existing.

7.4 Not treated as pre-existing

- High blood pressure or high cholesterol controlled by medication, with no hospital treatment for it in the 36-month look-back. Complications such as heart attack or stroke are shared as a new Need; maintenance medication follows Section 9.
- Type 2 diabetes that is well controlled without insulin, by oral medication or diet, with no hospital treatment for it in the 36-month look-back. Complications are shared as a new Need; maintenance medication follows Section 9.
- Preventive services (Section 6), which are never subject to these limits.
- Injuries from an accident that happens after the Start Date, even if they affect a body part treated earlier.

A complication of a condition listed above that had signs, symptoms, testing, diagnosis or treatment in the 36-month look-back is itself a pre-existing condition. Only complications that first appear after the Start Date are shared as a new Need.

7.5 Related services

While a condition is inside its phase-in limit, the same limit applies to:

- prescriptions for that condition,
- a recurrence of a prior cancer or chronic illness,
- reconstruction or implant replacement tied to a prior condition, and
- transplants for a pre-existing condition (Section 7.1).

7.6 Moving between memberships

A member who moves between the TOR Health Employee and Individual Memberships with no gap keeps their months of membership for this schedule; the clock does not restart. A lapse restarts it (Section 3.7). Each bill is shared under the phase-in limits of the membership the member holds on its date of service. The Individual Membership's limits are $15,000 in total through month 24 and $30,000 in total through month 36. Amounts shared for a condition under either membership count toward the limit that applies on a bill's date of service.

7.7 How pre-existing status is determined

Pre-existing status is decided when a Need is submitted, not at enrollment. The member's Approved DPC Provider supplies DPC records where the member has them, and TOR Health makes the determination. TOR Health may require a statement from the member's treating physician on a standard form. A member may ask in writing, before the Start Date, for a written ruling on whether a specific condition is pre-existing, which TOR Health will follow when it reviews Needs for that condition. A ruling is void if it was based on incomplete or inaccurate information from the member.

8. Maternity and newborns

Maternity is shareable when the expected delivery date is at least **10 months** after the mother's Start Date.

- **Prenatal care.** For a shareable pregnancy, routine prenatal care is shared with no IUA. Prenatal preventive screenings are shared with no IUA (Section 6) whatever the delivery date.
- **Delivery and other maternity care** are one Need. The maternity IUA is twice the household's selected IUA, up to $5,000, and applies at delivery, or toward a global maternity package (Section 5). A non-emergency (elective) Cesarean delivery has a fixed maternity IUA of $7,500.
- **Pregnancy at enrollment.** A pregnancy that exists on the Start Date, or with an expected delivery date less than 10 months after it, is limited to preventive screenings. Complications are not shared for that pregnancy, except miscarriage. The exception for a new employer below is the only other exception.
- **Pregnancies underway when a new employer is added.** A pregnancy that exists on a new member's Start Date, or that has an expected delivery date less than 10 months after it, is shared as maternity when the member is billed through the list bill of a participating employer that has at least 10 enrolled employees on that Start Date, and that employer's employees are first offered TOR Health on that date. All commonly owned or affiliated employers count as one employer, and this applies only once per employer. The maternity IUA for that pregnancy is $5,000, and the per-pregnancy limit applies. TOR Health determines the number of enrolled employees and the date employees were first offered TOR Health from its own records.

- **Miscarriage** is shared as a regular Need with the standard IUA, including a pregnancy that existed at enrollment.
- **Per-pregnancy limit.** Sharing is limited to $300,000 per pregnancy, including prenatal care, delivery, complications to the mother and postpartum care. The newborn's own care does not count toward this limit.
- **When the maternity Need ends.** The mother's maternity Need ends 60 days after delivery. A condition unrelated to the pregnancy is always a separate Need. A complication caused by the pregnancy that is still being treated after 60 days stays within the maternity Need and its limit.
- **Newborns.** A newborn added within 30 days of birth is a member from birth. The newborn's own care is a separate Need from the mother's, and the 48-hour newborn visit is preventive. A newborn's congenital, hereditary, genetic, neonatal and prematurity-related conditions are never pre-existing. The newborn's Needs have their own $300,000 per-Need maximum. When the mother's pregnancy was not shareable as maternity, including when the mother is not a member, the newborn's care for conditions present at birth is considered for sharing up to $50,000 in total. This includes congenital, hereditary and genetic conditions, prematurity, and care during the birth hospitalization, including NICU care, whenever those conditions are diagnosed and for as long as they are treated. The newborn's other care is shared as usual. An adopted child is treated like any other member: the pre-existing condition rules in Section 7 apply, measured from the child's own Start Date. However, a child adopted or placed for adoption before age 18 and added within 30 days is treated like a newborn for congenital and genetic conditions the parents did not know about when the child was placed.

9. Prescriptions

9.1 Medications available through other programs

Medications a member receives at no cost through another program are not shared. Other prescriptions are shared only as described in this section. Over-the-counter medications are not shared.

- **Preventive medications.** Preventive medications recommended under the federal guidelines in Section 6.1 are shared at no IUA only when the member cannot get them at no cost through another health plan or program, with clinical documentation when requested. Contraceptive drugs, HIV PrEP drugs and emergency contraception are not shared (Section 6.4). Preventive medications are never subject to pre-existing condition limits.
- **Weight loss.** GLP-1 and other drugs prescribed only for weight loss are not shared.

9.2 Shared prescriptions

Prescriptions are shared for the first **120 days of treatment** for a new Need, as part of that Need and subject to its IUA.

- **Maintenance medications** for ongoing or chronic conditions are not shared beyond the 120 days.
- **Exceptions:** cancer treatment drugs are shared for the course of treatment, within the per-Need maximum. Anti-rejection drugs after a shared transplant are shared for up to 12 months, outside the per-Need maximum (Section 9.3).
- **Inpatient medications** are shared as part of the stay.
- **Pre-existing conditions:** prescriptions follow the phase-in in Section 7.

- **GLP-1 drugs** prescribed for type 2 diabetes follow these rules, including the 120-day limit.
- **Non-preventive cholesterol drugs**, such as PCSK9 inhibitors, follow the maintenance and specialty drug rules: shared only within the first 120 days of treatment for a new Need, after the IUA, coordinated in advance, and subject to the pre-existing condition phase-in in Section 7.
- **Specialty drugs** follow the 120-day limit above and the $300,000 per-Need limit, and must be coordinated in advance. Gene therapy and cell therapy (Key terms) are not shared (Section 10.2).
- **Specialty drug cost controls.** When clinically appropriate, TOR Health may require generic or biosimilar alternatives, lower-cost pharmacies or infusion sites, and reasonable cooperation with manufacturer copay or patient-assistance programs. If a member declines an appropriate alternative, sharing may be limited to the reasonable price of the appropriate alternative, except for documented treatment failure, contraindication or urgency.

For medications tied to a shareable Need, members pay for prescriptions until the IUA is met and submit receipts so the payments count toward the IUA. After the IUA is met, eligible medications are considered for sharing and may be shared with the member, or paid with a digital payment card arranged through care navigation.

9.3 Transplants

Transplants. When the recipient is a member, the transplant is shared under the $300,000 per-Need maximum, including the donor's testing, related medical expenses and organ removal, whether or not the donor is a member, unless the donor's own coverage pays. Anti-rejection drugs after a shared transplant are shared for up to 12 months, and these drugs do not count toward the $300,000 maximum. When a member donates to a recipient who is not a member, TOR Health shares the member's testing, related medical expenses and removal, but the recipient's health plan pays first when it covers donor expenses. Transplants require pre-notification.

10. Limited and non-shareable services

10.1 Limited services

Service	Limit (after the IUA)
Outpatient counseling	Up to $1,500 per member per membership year
Inpatient psychiatric care	$7,000 per Need
Substance-use treatment	$3,000 per Need
ADD/ADHD and autism services, excluding ABA therapy	$3,000 per member per membership year. Medications follow Section 9
Outpatient therapy: chiropractic, osteopathic manipulation, acupuncture, physical, occupational, speech, vision and respiratory therapy, and cardiac rehab	50 visits per member per membership year, combined across all of these. Chiropractic is also limited to $3,000 per Need and $3,000 per membership year, and osteopathic manipulation to $3,000 per Need
Hospice	$200 a day, up to 180 days per member, coordinated in advance
Skilled nursing	60 days or $25,000 per Need, whichever comes first
Home nursing (short-term skilled home health)	$200 a day, up to 90 days per Need, coordinated in advance

Service	Limit (after the IUA)
End-stage renal disease	Once the member is eligible for Medicare because of end-stage renal disease, sharing is limited to what would remain after Medicare Parts A and B pay, whether or not the member enrolls. Before that date, shared as a regular Need
Cataract surgery	$4,000 per eye. Each eye is a separate Need
Temporomandibular joint (TMJ) disorder	$3,000 per member, lifetime
Varicose vein procedures, when a physician documents a significant medical risk (cosmetic procedures are not shared)	$3,000 per member, lifetime
Hearing aids, when hearing loss results from a new injury or new acute illness after the Start Date	Once per member, at 50% of the cost, up to $1,000
Neuropsychological testing, for a member under 18 or with a brain injury, when no public program pays for it	Once per member, up to $3,000
Tobacco users age 50 and older	Until cessation is proven, up to $25,000 per member for each of: cancer; respiratory disease; vascular disease, including coronary disease and stroke; oral and esophageal disease; and gastric and duodenal ulcers

Depression and behavioral screenings are preventive (Section 6) and not counted against these limits.

Outpatient therapy. Chiropractic care is shared only for a specific musculoskeletal injury or disease. Chiropractic care and osteopathic manipulation are not shared for members under 18. Maintenance treatment, meaning care to keep a stable condition from getting worse rather than to treat an injury or illness, is not shared for any therapy in the outpatient therapy limit. Acupuncture is shared for an eligible illness, within the outpatient therapy limit.

Mental health and substance use.

- **Suicide and self-harm.** Emergency stabilization and medical treatment of a self-inflicted injury or attempted suicide are shared for members of any age. Follow-up psychiatric care is subject to the inpatient psychiatric limit above.
- **Overdoses.** Emergency medical stabilization after an overdose is shared as an emergency. Treatment or rehabilitation after stabilization falls under the substance-use treatment limit.
- **Eating disorders.** Treatment of eating disorders follows the outpatient counseling and inpatient psychiatric limits above.
- **Mixed admissions.** An admission involving both a psychiatric condition and substance use is judged by its main clinical purpose. Psychiatric stabilization counts toward the inpatient psychiatric limit, and addiction treatment counts toward the substance-use treatment limit.
- **Medications.** Psychiatric and ADD/ADHD medications follow Section 9 and do not count toward the limits above.

Proof of cessation. A member proves cessation after 12 consecutive months without tobacco use by sending TOR Health: (a) the member's signed statement of the date they last used a tobacco product, signed by a parent for a child; (b) a written statement from the member's Approved DPC Provider, if the member has one, that the member has reported no tobacco use for those 12 months; and (c) a negative test taken in the last month of the 12, at the member's own cost. The test is a nicotine (cotinine) test or, for a member who uses nicotine pouches or nicotine replacement products, a test that tells tobacco apart from other nicotine, such as an anabasine test. Using nicotine pouches or nicotine replacement products during the 12 months does not restart them. The tobacco limits above and the additional contribution in Section 4.1 end on the first of the month after TOR Health receives the proof.

10.2 Not shared

- Contraception, emergency contraception and HIV PrEP drugs (Section 6.4).
- Chronic maintenance medications beyond the 120 days in Section 9.2, and medications a member receives at no cost through another program.
- Care received while not an eligible member, or before the Start Date.
- Cosmetic procedures, except reconstruction after a shared injury or illness.
- Routine dental, vision and hearing care.
- Experimental or investigational treatment.
- Gene therapy and cell therapy (Key terms).
- Weight-loss programs, drugs prescribed only for weight loss (including GLP-1 drugs), and bariatric surgery, including gastric bypass. Treatment of independently eligible conditions, such as diabetes or heart disease, may be shared.
- Fertility and assisted reproduction, including IVF, IUI, fertility medications, egg or sperm preservation, donor eggs or sperm, and surrogacy. Medically necessary treatment of reproductive disease, such as endometriosis, PCOS or fibroids, may be shared, and a pregnancy from assisted conception follows the normal maternity rules.
- Sterilization and its reversal.
- Gender-transition services, including hormone therapy, puberty blockers and surgery. Counseling is shared under the outpatient counseling limit (Section 10.1).
- Abortion. Miscarriage is shared (Section 8).
- Doula services.
- Applied behavior analysis (ABA) therapy.
- Growth hormone.
- Ketamine and ketamine-derived drugs, including esketamine, except when used for anesthesia, procedural sedation or emergency care.

- CBD (cannabidiol) products, except FDA-approved prescription drugs such as Epidiolex, which follow Section 9.
- Marijuana and cannabis products, including medical marijuana.
- Homeopathic treatments and remedies.
- Injuries or illnesses from active participation as a combatant in an armed conflict, other than acting in self-defense or in defense of home.
- Injuries or illnesses from participating in a riot.
- Assisted suicide and euthanasia, including related medical expenses.
- Injuries to the operator or a rider of a motor vehicle, including off-road vehicles, motorized watercraft and aircraft, when the operator or rider was not licensed as the law requires, was taking part in formal racing or stunt competition, or was operating the vehicle recklessly.
- Injuries to teeth from chewing or grinding, and wisdom tooth extraction.
- Treatment of erectile dysfunction. Diagnosis and treatment of an underlying condition, such as diabetes or prostate disease, are shared as usual.
- Interest, late fees and finance charges, including interest on money borrowed to pay medical bills. When borrowing lets a member pay early and save at least 30% compared with the reasonable price for that bill, the interest is shared.
- Genetic testing without a documented diagnostic or treatment indication, including elective ancestry, wellness and broad screening. Genetic testing with a documented diagnostic or treatment indication, and high-risk predictive testing with a documented clinical indication after clinical review, may be shared, with no separate cap.
- Allergy testing and allergy immunotherapy (shots or drops). Acute allergic reactions are shared as normal Needs, except that recurrent reactions may be pre-existing (Section 7.1).
- Preventive (risk-reducing) surgery, such as a preventive mastectomy, without a personal history of the diagnosis and a doctor’s recommendation. A member with a personal history of cancer whose doctor recommends preventive surgery, such as removing the other breast, may have that surgery shared as a regular Need after pre-notification. A positive genetic test alone does not make preventive surgery shareable.
- For members 18 and older, injuries or illnesses resulting from an illegal act for which the member is convicted, or pleads guilty or no contest, including deferred adjudication or diversion, or from the member’s intoxication by alcohol or drugs. While charges are pending, TOR Health may hold sharing for that Need, and it may recover amounts already shared if the member is later convicted.
- Costs the member is not obligated to pay.

Injuries from recreation and sports, including skiing, motorcycles and amateur sports, are not excluded because the activity carries risk. Only the exclusions above for illegal acts, intoxication, armed conflict, riots, and racing, stunts or unlicensed or reckless vehicle operation apply.

10.3 Clinical standards

These standards supplement Sections 4 through 10. Where they conflict with a specific limit elsewhere, the specific limit governs.

Post-acute care. Medically necessary inpatient rehabilitation and long-term acute care are shared within the $300,000 per-Need maximum, with pre-notification for planned care. Short-term skilled home health is shared up to $200 a day for up to 90 days per Need (Section 10.1). The skilled nursing (60 days or $25,000 per Need), therapy (50 visits a membership year) and hospice limits still apply. Custodial care, assisted living, personal care, home modifications and private-duty nursing are not shared unless TOR Health approves them in advance.

Medical equipment and prosthetics. Prescribed external medical equipment and prosthetics, such as wheelchairs, walkers, hospital beds, home oxygen, braces and artificial limbs, are shared when they are a necessary part of treating an eligible Need. The member pays 20% of the cost, and the remaining 80% is considered for sharing, limited to $10,000 per Need. TOR Health shares the lower of renting or buying the equipment for the expected length of use, and care navigation helps choose. Replacing equipment for growth or wear is not shared, except prosthetic limbs and braces for children, as described below. Repairs and maintenance, upgrades, lost or damaged equipment, and home or vehicle modifications are not shared.

Children's prosthetic limbs and braces. For a member under 18, replacing a prescribed prosthetic limb or brace the child has outgrown is considered for sharing at 80% of the cost, limited to $10,000 in total per child for all such replacements until age 18. This is in addition to the original item. A doctor must document that the child has outgrown it.

Implanted devices. Implanted devices, such as pacemakers or joint replacements, are shared as part of the Need within the per-Need maximum. Replacing an implanted device that fails or wears out is a new Need. If the device was put in for a pre-existing condition (Section 7.1), the pre-existing condition rules in Section 7.5 apply.

Medical supplies. Prescribed medical supplies for a shareable Need, such as wound dressings, catheters, ostomy supplies and diabetic testing supplies, are shared as part of that Need and subject to its IUA, for the first 120 days of treatment for the Need. The 20% member share for equipment does not apply. Supplies for an ongoing or chronic condition are not shared after the 120 days, the same as maintenance medications (Section 9.2). Supplies used during a hospital stay, procedure or office visit are shared as part of that bill. Over-the-counter supplies are not shared unless a doctor prescribes them for a shareable Need. Supplies for a pre-existing condition follow the phase-in in Section 7.

Ambulance and transport. Medically necessary emergency ground ambulance and clinically required transport between facilities are shared. Air ambulance is shared up to $25,000 per trip. Routine and convenience transport is not shared.

Emergency complications of excluded care. Emergency stabilization of an acute, life-threatening complication of an excluded procedure, and the care needed to restore general health, may be shared as a separate Need. The original procedure, later non-emergency treatment, and any revision of a cosmetic result are not shared.

Sleep medicine. Diagnostic sleep studies and initial CPAP or BiPAP equipment for a new diagnosis are shared up to $2,500. Oral appliances such as mouth guards, implanted devices and surgery are shared after clinical review. Replacement equipment and routine masks, filters and tubing are not shared.

International care. Emergency or unexpected care during temporary international travel is shared under the normal rules. Planned international care needs advance approval. Medical evacuation is not shared unless TOR Health approves it, and travel and lodging for care outside the United States are not shared. Bills for care outside the United States must be itemized, translated into English and converted to U.S. dollars.

Travel for lower-cost care. Basic travel and lodging for the member and one companion are shared when care navigation confirms that the care plus travel costs the community at least 20% less, including travel, than care close to home.

Integrative care, dental, vision, hearing and dermatology. Evidence-based treatment of an eligible illness is shared whatever the provider's label. Naturopathic and holistic care is shared only when provided by a licensed medical practitioner. Testing and treatment for mold toxicity are shared only with documentation of dangerous mold levels where the member lives or recently stayed. Treatment for chronic Lyme disease is shared only when Lyme disease was confirmed at the initial diagnosis by ELISA or Western blot testing, or by the characteristic bull's-eye rash. Supplements, detox programs, colonics, massage therapy, non-evidence-based tests and elective IV vitamins are not shared. Hands-on techniques given as part of a physical therapy or chiropractic visit are shared within that visit's limits. Routine dental, vision and hearing care is not shared, but medically necessary treatment of trauma, disease or cancer is. Medical dermatology and skin cancer care are shared; cosmetic care is not.

11. Guideline changes, appeals and notices

11.1 Changes to these guidelines

- The TOR Health Employee Membership guidelines may be updated up to **twice a year**. Changes take effect on the first day of a month, on the same date for all employee members, at least 60 days after the changes are announced.
- Members are notified by email and in the member portal at least 60 days before any change takes effect. No signature is required; continued payment of shares is acceptance.
- Each bill is judged under the guidelines in effect on its date of service. Past versions are published on the TOR Health website.

11.2 Written rulings

Only written determinations from TOR Health state how these guidelines apply to a Need. Spoken guidance from care navigation or staff is not a determination.

11.3 Appeals

1. The member may ask for reconsideration in writing within 60 days of a determination. A TOR Health manager not involved in the original decision reviews it.
2. Within 60 days of the reconsideration decision, the member may appeal in writing to a stewardship committee of the board.
3. Within 60 days of the committee's decision, the member may ask in writing for a final review by a panel of 7 randomly selected members. TOR Health and the member each submit a written position statement, and the panel may question both. A simple majority of four of the seven members decides whether the Need is shared.

TOR Health issues a written decision at each step within 30 days of receiving the member's request. A member who misses a 60-day deadline may not continue to the next step, unless TOR Health agrees the delay was for good cause.

Appeal protections. TOR Health expedites an appeal when delay could seriously harm the member's health. Every decision explains its reasons in writing and cites the guideline it relies on. Members may add evidence at any step and will not be treated differently for appealing. A clinical dispute about medical necessity is reviewed by a licensed clinician in the same or a similar specialty who was not involved in the original decision and has no financial stake in it. The appeals process does not create a contractual promise or a legally enforceable right to the sharing of any Need.

11.4 Mediation and binding arbitration

Members and TOR Health agree to resolve disputes within the community rather than in court.

1. **Appeals first.** A member must complete the appeal steps in Section 11.3 before starting mediation on a sharing decision.
2. **Mediation.** Any claim or dispute arising out of or related to these guidelines, the membership, or TOR Health, ClearBook Health or their directors, officers, employees, agents or contractors goes first to mediation before a single mediator. The parties split the mediator's cost equally.
3. **Binding arbitration.** If the dispute is not resolved within 30 days after mediation, it is settled by binding arbitration before a single arbitrator under the Commercial Arbitration Rules of the American Arbitration Association then in effect. The arbitrator's decision is final, and judgment on it may be entered in any court with jurisdiction. The parties split the arbitration costs equally and each pays its own attorneys' fees, unless the arbitrator finds a party acted in bad faith.
4. **Place and law.** Mediation and arbitration take place in Travis County, Texas, and are governed by Texas law.
5. **Waiver of court claims.** Mediation and arbitration are the sole remedy for any such dispute. To the fullest extent the law allows, members, TOR Health and ClearBook Health waive the right to sue one another in court, the right to a jury trial, and the right to bring or join any class, collective or representative action, in court or in arbitration. Either party may go to court only to enforce an arbitration award or to seek injunctive relief.

By enrolling, each adult member agrees to this section on behalf of their household, and so does each person who signs the attestation later under Section 2.3.

11.5 Required notices

State-required notices appear in Section 12.

11.6 Member information and privacy

TOR Health collects and uses members' personal, medical and payment information only to run the membership: to enroll members, collect shares, review and share Needs, coordinate care, negotiate bills, pay providers, prevent fraud and meet legal requirements. TOR Health does not sell members' information or use it for advertising.

TOR Health shares only the information each needs with:

- the member's Approved DPC Provider and care navigation team;

- TOR Health's enrollment, billing and member portal providers;
- the bank that issues TOR Health payment cards, and its program manager, card platform and payment processors. They verify each adult cardholder's identity when the member is set up for cards, using name, address, date of birth, phone and email, and in some cases a government ID. They also process card payments, which record the provider's name and the amount;
- providers and their billing agents, to get records and negotiate bills;
- other payers that may be responsible for a Need (Section 5); and
- government agencies, auditors and others when the law requires.

The card bank and its partners handle cardholder information under their own terms and privacy policies, which a cardholder accepts by using a card. They may keep that information after membership ends when the law requires. TOR Health's service providers must protect members' information and use it only for TOR Health. TOR Health does not put diagnoses or other medical details on payment cards or in payment records. Members may ask TOR Health for the current list of its payment and technology providers and for the information it holds about them, and may ask to correct that information.

12. State notices and disclosures

Certain states require a health care sharing organization to give members a specific written notice. The notices below are part of these guidelines and accompany every application and guideline document TOR Health distributes. If a notice for your state of residence appears below, it applies to you in addition to the notice in Section 12.1.

12.1 Notice to all members

NOTICE: TOR Health is operated by ClearBook Health, a Texas nonprofit. Neither is an insurance company, and the TOR Health Employee Membership is not insurance or an insurance policy and is not offered through an insurance company. TOR Health is not a discount health care program. Neither TOR Health nor any member assumes any risk or promises to pay any member's medical bills, and no member can be compelled by law to contribute toward another member's medical bills. Whether or not you receive any amounts for medical expenses, and whether or not TOR Health continues to operate, you are always personally responsible for paying your own medical bills. TOR Health membership is not subject to the regulatory requirements or consumer protections of your state's insurance code. Membership is not creditable coverage.

12.2 Georgia

Official Code of Georgia Annotated § 33-1-20.

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

12.3 Texas

Texas Insurance Code, Chapter 1681, § 1681.002.

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

12.4 Commitments that support these notices

Consistent with Texas Insurance Code § 1681.001 and Georgia's safe-harbor requirements, TOR Health:

- sends every member a written monthly statement showing the total dollar amount of eligible Needs submitted, the amount actually shared, and how the member's own contributions were allocated on the member-to-member ledger;
- discloses its administrative fees and costs to members (Section 4.1);
- makes sure every payment card TOR Health gives a member is delivered with, and displayed alongside, a clear statement that the member is part of a health care sharing ministry that is not engaging in the business of insurance; and
- does not operate a discount health care program.

12.5 Other states

Members who live in a state not listed above will find any notice their state requires at jointorhealth.org. Those notices are part of these guidelines.
