# WAVELENGTH HEALTH PLAN

## INDIVIDUAL/FAMILY SUBSCRIPTION PLAN AGREEMENT

*This Agreement describes the terms and conditions of membership in the Spectrum Health Care Subscription Medical Plan.*

This Plan Agreement ("Agreement") is entered into as of the _____ day of _____, 20_____ , and effective on the _____ day of _____, 20_____ , between You ("Plan Member" or "Patient") and Spectrum Health Care and its Primary Health Clinic located at 1123 Wilkes Boulevard, Suite 100, Columbia, Missouri, 65201 ("Provider") under which the Provider, or their covering Provider, will make certain health and wellness services, amenities, and enhanced services ("Services") available to You which may not otherwise covered by commercial insurance, managed care, Medicare and/or other third party payers. By voluntarily entering into this Agreement and remitting the Plan Fee (as set forth below), You may participate in the Provider's Wavelength Health Plan ("Plan") for a period of twelve (12) months beginning on the Effective Date.

1. **Background:** The Provider, who specializes in general medicine, and delivers care in exchange for Plan Fees paid by You according to the terms of this Agreement.

2. **Patient:** A Patient is defined as those persons for whom the Provider shall provide Services, and who are signatories to, or listed on these documents as a subscribing Plan Member. The term "You" or "Patient" shall refer to all adult parties to this Agreement (including a Patient's legal representative), as well as any minor children for whom the parent or guardian requests that services be provided under this Agreement. Parents or legal guardians shall sign on behalf of the minor or dependent. See signature pages to enroll minor children or dependents.

3. **Limitations on Age:**
   - Person's between the ages of 5 and 17 are accepted as Patients only if their parent is a Plan Member as well.
   - Children under the age of 5 are not accepted on this plan.
   - While Provider does see children over the age of 5 for emergent need visits (i.e bumps and bruises, colds, minor infections, etc.), Provider does not provide recommended American Pediatric Association of child-wellness exams and immunizations.

4. **The Plan:** The Plan Fee covers the following services and amenities provided by the Provider as set forth below:
   Services (see Exhibit 1): **Some restrictions apply.*
   - Annual Physical Exam*****
   - Annual Flu Shot
   - Hepatitis A/B Vaccine (depending on plan selected)
   - 4 to Unlimited Office Visits (depending on plan selected)
   - 6 to Unlimited Telemedicine Consultations (depending on plan selected)
   - Integrated Behavioral Health (depending on plan)
   - Referral to partners for specialized services, testing, and treatment
   - Access to negotiated rates for provider partners, pharmacy, laboratory services, and more
   - Nutritional Services, Mental Health Services, Gym membership discounts, and more (coming soon)*****

Enhancements:

- Same Day/Next Day Appointments

Program Member is offered same-day or next-day appointments, during normal business hours, for any medical care. Communications for urgent matters should be made by phone call to the office telephone number. Communication for non-urgent matters between the doctor or his/her designee and Plan Member will be made within a business day and a plan will be made between them for any further follow-up necessary.

- Visitors

Family members* temporarily visiting a Patient from out of town may, for a two- week period, take advantage of the services described in Same Day/Next Day Appointments. Medical services rendered to Patient's visitors shall be charged on a fee-for-service basis.

** Family members who are Medicare beneficiaries must be covered by a Medicare opt out and waiver agreement in order to be treated by a Spectrum Health Care Provider.*

- Email/Text Communication

Plan Members will be provided with a phone number, facsimile and email address for contacting designated Provider or designee, and detailed instructions on how to contact Provider 24/7 for questions or requests through these means.

- 24/7 Availability

Provider or, when applicable a covering designee, 24/7 availability that is medically necessary is covered by Plan, not part of this Membership Agreement and payment of Membership Fees is not a condition of receipt of such medical services. When not medically necessary, arrangements will be made for Provider or covering designee to be available generally to personally communicate with Plan Member, at all times to a reasonable extent, through telephone or telephone call enhancements. The response time and the method of communication will be appropriate to the purpose of the communications. **If the matter is possibly life threatening, 911 should be contacted first** and then, if possible, call the Provider.

- Comprehensive Health Planning

Arrangements will be made for Provider to provide an annual health planning assessment to set Plan Member's annual health goals and to evaluate Plan Member's progress in achieving those goals. The parameters of this annual health assessment will include only items that are not covered by Plan Member's insurance, health plan or any governmental entity, including Medicare. Arrangements will also be made for the Provider to be available to coach Plan Member to address obstacles to health improvement.

- Office Amenities

Program Member will have access to a comfortable, well-appointed and semi-private waiting area.

- Health Information

Arrangements will be made to provide Plan Member with regular personalized health information on topics pertinent to Plan Member's health, including bulletins, health articles and website postings. Any such information will be conveyed via web posting or email. Arrangements may also be made to arrange for Plan Member to attend education, lecture, support group and discussion sessions, at Plan Member's choice. *Plan Member may be required to pay registration fees, if any, for such sessions.*

- Specialists

Provider shall coordinate with medical specialists to whom Patient is referred to assist Patient in obtaining specialty care. Patient understands that fees paid under this Agreement do not include and do not cover specialists' fees or fees due to any medical professional other than the Spectrum Health Care Providers. When possible, the Patient will be referred to Providers that have agreed to provide the lowest cost possible for Services outside of the Plan.

5. **Assignment:** This Agreement, and any rights Patient may have under it, may not be assigned or transferred by Patient to another party.

## 6. Plan Fee:

- Individual plans start at $50 per month (see Exhibit 1).
- Initial Plan Fee payment is due on enrollment and may be paid by credit/debit card or check/money order payable to Spectrum Health Care or cash. Subsequent payments are payable by credit/debit card; or by mailing check/money order. **DO NOT MAIL CASH.** You must pre-authorize a reoccurring credit/debit card charge for 12 months at the time of the enrollment in the Plan.
- The Plan Fee will be charged to Your credit or debit card on the day prior to the effective date of this agreement for effective enrollment for the following month. If payment is denied, we will attempt to process the following day. If denied a second time, we will contact You directly and You will have five (5) days to update payment information and have Your payment processed. If not renewed at that time, Your membership in the Plan may be canceled.
- Failure to pay Your Plan Fee may result in termination of Your membership in the Plan.
- You may elect to prepay the Plan Fee on an annual basis and by doing so, will ensure continuity of Services.
- We offer a 5% family discount when more than three or more individuals living in the same household are enrolled in the Plan and prepaying annually. **NOTE:** Only one payment option is allowed (i.e. payment is made from one single source, not from each Plan member).

## 7. Renewals and Termination:

- The term of this Agreement shall be for one (1) year from the Effective Date and shall hold pricing without an increase or reduction of services available during that time.
- At the end of each one-year term, if rates or services have changed, You will be asked to reenroll.
- If no changes are made to Your Plan, Your Plan will automatically renew under the same terms and conditions.
- Termination requires written notice thirty (30) days in advance of the anniversary of Your Effective Date.
- If terminated with appropriate notice and have prepaid Your Plan fee, Your prepaid fee is refundable on a prorated basis.
- Your failure to renew in the Plan will be taken as Your decision to immediately establish Yourself with a new Provider. You must request in writing a refund of any prepaid Plan Fees. Prorating of such refund will start once the written request for termination and any refund available is received.
- If terminating from the Plan and moving to a different Provider, You must sign a HIPAA compliant request to have Your records transferred to Your new Provider. One copy of Your records will be provided to Your Provider at no charge. **NOTE:** Any additional copies of Your records will be charge for at the current rates. The current rate as of September 20, 2020 is $0.56/page and any postage/delivery fees as applicable. You will be provided with an itemized receipt for copying and delivery.

## 8. Medical Care Services Excluded from this Plan Fee:

- The Provider will not seek reimbursement from any insurer, Medicare, or other third-party payer for the Plan Fee or for services that are included in this Agreement. You are solely responsible for payment of the Plan Fee and agree not to submit the Plan Fee to Medicare or Your private insurance carrier, except for reimbursement from Your health savings account ("HSA"), medical savings account ("MSA") or Flexible Benefits Account ("FBA").
- The Provider will bill You or Your insurer for items agreed to but not included in this Agreement (see Exhibit 1). By agreeing to treatment or services rendered outside the Services listed in this Agreement, You and/or Your insurer shall be financially liable for these Services.

## 9. Laboratory Testing:

- Should You require laboratory testing not available in our office, Provider will refer You to a contracted laboratory testing site with which Provider has negotiated rates; or a laboratory testing site which is in Your insurance network.

- In addition, if You require additional tests that are not offered by the laboratory testing site with which the Provider has an agreement, You will be responsible for the costs of any such testing.

10. **Limitations on Prescriptions for Controlled Substances:** Provider may prescribe certain controlled substances for You from time to time as she deems medically appropriate. However, Provider does not provide long-term chronic pain management. As part of this Agreement, You must execute the Controlled Substances Acknowledgement Form (Exhibit 2) indicating Your understanding that Provider will not prescribe controlled substances on an on-going basis. Should You need long-term chronic pain management, Provider can recommend another provider to assist You in the care and treatment of Your pain management issues.

11. **Co-Payment:**
    - No co-payments are required at time of service for any services listed in this Agreement.
    - Co-payments, deductibles, and out-of-pocket expenses, as dictated by Your insurer, remain Your financial responsibly for services not included in the Agreement.

12. **Non-Participating Provider:** If Spectrum Health Care is not a participating provider with Your insurance, the Provider will file a claim with Your insurance company as a courtesy only with respect to services that are not included in this Agreement. If declined, You will be responsible for those charges.

13. **Current Medical Health Insurance:** If You have a major medical health plan, policy information may be completed in Exhibit 3. This will only be utilized for billing purposes when specific, pre-agreed upon services not covered by this plan, are requested or needed.

14. **Email/Text Communications/Privacy:**
    - You acknowledge that traditional email and text is not a secure way for sending or receiving personal health information.
    - If You choose to send confidential personal health information to non-secure email or text, You specifically authorize the Provider to reply with personally identifiable protected health information.
    - The Provider will have sole discretion as to whether or not to reply to any email or text communication with said health information and whether or not to open email attachments.
    - Emails and texts may become part of Your medical record.
    - You also acknowledge You will not use email or texts to seek an urgent appointment, ask questions about an urgent issue, or for any other time-sensitive issue.
    - If You have time-sensitive issues, You must contact the Provider by telephone or in person at the office. **NOTE:** During the current COVID-19 health crisis, no walk-ins are accepted. Please call in advance to ensure availability of staff and access to the office.
    - You agree that You will not use email or text for solicitation or advertising purposes to the Provider or staff. By doing so more than once in error, You will be removed from the Provider's allowable email and text communication list.
    - See Exhibit 4 for email and text communication enrollment, and how to communicate electronically with Spectrum Health Care and our Providers. Absolutely no email or text communication will take place between You and Provider or its designee without Exhibit 4 being executed.

15. **Amendment and Waivers:**
    - This Agreement may only be revoked, altered, amended, or modified by the written agreement of both parties hereto.
    - No Waiver of any provisions of this Agreement shall be valid unless in writing and signed by the party against whom such waiver is sought.

- One or more waivers of any covenant of condition of the Agreement by any of the parties hereto shall not be construed as a waiver of any subsequent breach of the same provision of any other covenants or conditions.

16. **Section Headings:** Any section, section title, or caption contained in this Agreement is for convenience only and in no way defines, limits or describes the scope of intent of this Agreement or any of the provisions hereof.

17. **Invalid Provisions:**
    - The invalidity or unenforceability of any particular provision of this Agreement shall not affect any other provision hereof.
    - This Agreement shall be construed in all respects as if such invalid or unenforceable provisions were omitted.

18. **Entire Agreement:**
    - This Agreement constitutes the entire understanding of the parties with respect to the subject matter outlined in this Agreement.
    - The undersigned agrees to the terms and conditions of this Agreement and acknowledges there are no promises or representations except as specifically listed in this Agreement.

19. **Notices:**
    - Notice from one party to the other shall be in writing and shall be deemed to have been duly given when delivered in person, sent via Email with a "Read Receipt" (normally found under "options" in your email client with an option to request read and/or delivery receipts – you must select "read") or sent via the U.S.P.S. mail with "Proof of Delivery" (this is part of Certified Mail, but may also be selected as an additional option at the Post Office) to the address listed in this Agreement.
    - Patient contact and billing information is found in Exhibit 5.

20. **Governing Law:** This Agreement shall be governed by and construed in accordance with the laws of the State of Missouri. THE PARTIES INTENTIONALLY AND VOLUNTARILY WAIVE ANY RIGHT TO A TRIAL BY JURY IN ANY MATTER ARISING OUT OF THIS AGREEMENT. ANY DISPUTE BETWEEN PROGRAM MEMBER AND CONCIERGE PRACTICE OR THEIR RESPECTIVE AFFILIATES AND AGENTS ARISING UNDER OR RELATING TO THIS AGREEMENT SHALL BE RESOLVED EXCLUSIVELY BY ARBITRATION IN BOONE COUNTY, STATE OF MISSOURI, BEFORE A NEUTRAL ARBITRATOR, under the auspices of the American Arbitration Association, in accordance with its then current Expedited Rules and Procedures for Commercial Arbitration. Any award rendered pursuant to such arbitration shall be final and binding upon the parties, and judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction over parties. Each party shall bear its own costs and attorneys' fees in connection with any such arbitration.

21. **No Liability:** Except as required by applicable law, Spectrum Health Care shall not be liable to Program Member for any damages or liability arising out of or related to the Agreement. In any event, each parties' liability under the Agreement, shall be limited to amount that is equal to the aggregate Membership Fees paid by the Program Member during the twelve-month period preceding the date on which the claim arises. In no event will any party be liable for any indirect, consequential, special or punitive damages of any kind, whether arising in contract, tort, strict liability or otherwise, to the full extent permitted by the applicable law arising out of or related to the Agreement.

22. **Change of Law:** If there is a change in any state or federal law, regulation or rule or interpretation thereof, which affects this Agreement or the activities of either party under this Agreement, and either party reasonably believes in good faith that the change will have a substantial adverse effect on that party's rights or obligations under this

Agreement, then that party may, upon written notice, require the other party to enter into good faith negotiations to renegotiate the terms of this Agreement. If the parties are unable to reach an agreement concerning the modification of this Agreement within thirty (30) days after the date of the notice seeking renegotiation, then either party may terminate this Agreement by written notice to the other party.

23. **Legal Significance:** Patient acknowledges that this Agreement is a legal document and creates certain rights and responsibilities. Patient also acknowledges having had a reasonable time to seek legal advice regarding the Agreement and has either chosen not to do so or has done so and is satisfied with the terms and conditions of the Agreement.

***END OF PLAN AGREEMENT DEFINITIONS AND SCOPE***

***SIGNATURE PAGES AND EXHIBITS FOLLOW***

## SIGNATURE PAGE 1 MINOR CHILDREN/DEPENDENTS

I wish to add children or dependents to this agreement:

### MINOR CHILDREN/DEPENDENTS TO BE COVERED UNDER THIS AGREEMENT

Please provide the names of any minor children, or dependents which you have legal responsibility for, to be covered by this Agreement:

| | |
|---|---|
| Printed Name | Relationship to Patien |
| Printed Name | Relationship to Patient |
| Printed Name | Relationship to Patient |
| Printed Name | Relationship to Patient |
| Printed Name of Parent/Guardian | Plan Level |
| Signature of Parent/Guardian | Date |

## SIGNATURE PAGE 2 ENROLLMENT/ACCEPTANCE

By signing this agreement, I acknowledge that I have received a copy of this Agreement and supporting documentation referred to herein.

I _____, agree to all the terms and conditions herein.
Patient Printed Name

I acknowledge that I understand the "Plan" is not an insurance product and that I have been advised that I will need to continue my own health insurance for services listed outside of the scope of services listed here. I have read and agree to all terms of the Provider's payment policies.

| | |
|---|---|
| _____ | _____ |
| Patient/Legal Representative Signature | Date |
| _____ | _____ |
| Print Patient Name | Plan Level |
| _____ | _____ |
| Print Legal Representative Name | Relationship to Patient |

Duplicate this page to provide signatures for each additional adult member enrolled.

Acknowledged and accepted by the Provider:

***Spectrum Health Care***

| | |
|---|---|
| _____ | _____ |
| Printed Name | Title |
| _____ | _____ |
| Signature | Date |

## EXHIBIT 1 SERVICES AND FEES DETAIL

| SERVICES INCLUDED | $50 BASIC | $70 STANDARD | $100 PREMIUM |
|---|---|---|---|
| ► Annual Physical Exam including:<br>• Basic annual bloodwork – Basic Chem Panel including: Essential Nutrients, Vitamin D, Complete Metabolic Panel and Complete Blood Count, Metabolic Markers, Inflammatory Markers<br>• EKG (where applicable)<br>• Urinalysis<br>• Blood Glucose Testing<br>• Cholesterol Testing<br>• Annual STD/STI testing – HIV, Chlamydia, Gonorrhea, Syphilis | ✓ | ✓ | Expanded where applicable |
| ► Annual Flu Shot (does not require an office visit, only an appointment to minimize wait and ensure staff availability) | ✓ | ✓ | ✓ |
| ► Hepatitis A/B Vaccine | n/a | n/a | ✓ |
| ► Office visits (beyond Annual Exam) | 4 visits | 6 visits | Unlimited |
| ► Telemedicine Consultations (via telephone, cell phone and/or video) | 6 visits | 10 visits | Unlimited |
| ► Integrated Behavioral Services | n/a | n/a | 4 visits |
| ► Referral to partners for specialized services, testing, and treatment | ✓ | ✓ | ✓ |
| ► Access to negotiated fees for provider partners, pharmacy, laboratory services, and more. | ✓ | ✓ | ✓ |
| ► Nutritional Services, Gym Services, Mental Health Services, etc. – COMING SOON! | ✓ | ✓ | Expanded |

## EXHIBIT 2 CONTROLLED SUBSTANCES ACKNOWLEDGEMENT FORM

Your Provider may prescribe certain controlled substances for You from time to time as they deem medically appropriate. However, Your Provider does not treat chronic pain and does not provide chronic pain management. As such, any controlled substances that may be prescribed to You will be prescribed on a limited, short-term basis. Should You require long-term, chronic pain management, Your Provider will refer You to a provider to treat Your chronic pain and/or will assist You in transferring Your care and treatment to the provider of Your choice.

By signing below, You understand and acknowledge that neither Your Provider nor the Provider provides long-term pain management/treatment services and that You will not be prescribed any controlled substances on a long-term basis. You further agree to inform Your Provider of all controlled substances that are prescribed to You by any other provider and acknowledge that this is an on-going obligation on Your part as a Patient of the Provider.

Acknowledged and accepted by the enrolled Member:

_____ _____

Patient/Legal Representative Signature Date

_____

Print Patient Name

_____ _____

Print Legal Representative Name Relationship to Patien

Duplicate this page with signatures for all enrolled Members.

## EXHIBIT 3 HEALTH INSURANCE INFORMATION

This information will only be used for agreed upon services not included under this Agreement.

I am currently uninsured: If you answered no, please provide your insurance information below.

☐ Please check here if Spectrum Health Care already has your current information on file.

| PRIMARY INSURANCE | OTHER INSURANCE |
|---|---|
| Insurance Company | Insurance Company |
| Name of Insured | Name of Insured |
| Group Number | Group Number |
| Identification Number | Identification Number |
| Insurance Company Phone Number | Insurance Company Phone Number |

You must notify the Spectrum Health Care as soon as possible of any changes in the information listed above. Nothing in the Agreement supersedes or modifies the terms or conditions of any agreements relating to your insurance.

## EXHIBIT 4 EMAIL AND TEXT COMMUNICATION

Complete items below for enrollment in the email and text communication list. No Program Member may be contacted through email or text communication if not listed here and confirmed by the Patient's signature. By doing so, You understand and accept the provisions in this section, including the following:

- ✓ No marketing, advertising, or sponsorship requests through email or text;
- ✓ No attachments to email or text;
- ✓ No patient-level data will be sent through email or text without additional express consent;
- ✓ No diagnosis will be given solely through email or text;
- ✓ Emails and texts may not be used to harass or make threats; may not be offensive or disruptive in nature; may not include language or images relating to race, gender, age, sexual orientation, pornography, religious or political beliefs, national origin, or disability;
- ✓ No requests for new medication will be processed through email or text; refill requests are potentially allowed through email or text depending on need for additional lab work, required office visit, or other reason stipulated by Provider; and
- ✓ Provider may choose to respond in a different method than the conversation started with, for example a text message may result in a phone call or follow-up email.

| Name of Patient Printed | Email | Cell phone | Patient's Signature |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## EXHIBIT 5 MEMBER CONTACT AND BILLING INFORMATION

Please provide contact information and credit/debit card details for billing of Plan Fee.

### CONTACT INFORMATION

Name: _____

Address: _____

City, State, ZIP: _____

Home Phone:_____

Cell phone:_____

Email: _____

### PLAN PAYMENT INFORMATION

Name on Card: _____

Card Number: _____

Expiration Date: _____

Security Code: _____

Billing ZIP Code: _____

Authorized Signature: _____

By completing this information with your signature, you authorize Spectrum Health Care to bill your credit/debit card for your Plan Fee until such time as a new Agreement is signed.

Amount to be billed: _____ First payment received: _____

You must notify the Spectrum Health Care as soon as possible of any changes in the information listed above. Nothing in the Agreement supersedes or modifies the terms or conditions of any agreements relating to your payment information with the exception of nonpayment of Plan Fee.