EBA Attestations and Participation

________**Initial** -By initialing, the applicant certifies he/she is self employed and does not have W-2 employees other than self. IRS.Gov- Who is Self-Employed?)

Health Disclosures

For each person applying for coverage, have they seen a medical provider, had treatment recommended, received care (including prescriptions) or been hospitalized for any of the following within the last 5 years.

Yes No

1. ☐ ☐ Have you or any of your dependents applying for coverage, been under the care of a doctor currently or in the past 5 years for any of the following conditions: cancer, heart disease (including Bypass), Heart Attack, Heart Surgery, or Stroke?

2. ☐ ☐ Have you or any of your dependents applying for coverage in the past 5 years been home bound or incapacitated or incapable of self-support due to a medical condition?

3. ☐ ☐ Have you or any of your dependents applying for covered, been under the care of a doctor currently or in the past 5 years for Autoimmune or blood disease i.e., Lupus MS, Anemia, AIDS, HIV, Hemophilia, IBS, Crohn's?

4. ☐ ☐ Have you or any of your dependents applying for coverage, been under the care of a doctor currently or in the past 5 years for Organ Failure or Organ Transplant for Kidney, Liver, Lung, Heart and or any form of organ support i.e., dialysis?

5. ☐ ☐ Are you or any of your dependents applying for coverage currently pregnant or expecting?

6. ☐ ☐ Have you or any of your dependents applying for coverage, currently being treated for condition(s) you have been hospitalized for in the past 5 years?

7. ☐ ☐ Have you or any of your dependents applying for coverage, been under the care of a doctor currently or in the past 5 years for respiratory disorders, Emphysema, Chronic Bronchitis, COPD or Chronic Pneumonia?

8. ☐ ☐ Have you or any of your dependents applying for coverage, been under the care of a doctor currently or in the past 5 years for musculoskeletal disorders i.e. Back Disorders, Muscular Dystrophy, Cerebral Palsy, Dermatomyositis, Compartment Syndrome, Sciatica or Osteoporosis?

9. ☐ ☐ Have you or any of your dependents applying for coverage, been under the care of a doctor currently or in the past 5 years for substance abuse or substance dependency?

10. ☐ ☐ Have you or any of your dependents applying for coverage, been under the care of a doctor currently or in the past 5 years as a Type 1 Diabetic?

11. ☐ ☐ Have you or any of your dependents applying for coverage, been under the care of a doctor currently or in the past 5 years for a previous major surgery? Or have an upcoming planned surgery?

Medication Disclosures

This plan excludes specialty medications, including human growth hormones. Specialty medications are defined broadly as medications classified as **high-cost, high complexity and/or high touch**. Specialty drugs are often **biologics**—"drugs derived from living cells" that are injectable or infused (although some are oral medications).

Due to this exclusion, this plan works with a 3rd party vendor that can source medication through Foundational Assistance based on qualifying set of criteria including income and household size.

For those medications that are on this formulary, the plan reserves the right to use means other than retail fill in the provision of your medications.

It is important to consider whether this policy will meet your needs if you are currently or anticipate taking specialty meds.

_____**Initial** I have read and understand that this plan excludes specialty medications.

PHI Disclosures

_______**Initial** By signing this application, I understand the following:. I certify that the statements are true and correct to the best of my knowledge. That knowingly false information submitted on this form constitutes fraud or intentional misrepresentation of material fact, the plan may rescind healthcare coverage.

_______**Initial** I understand that the plan will return any contributions that have previously been paid as to the rescinded coverage, minus claims paid

_______**Initial** I understand that this form is used for information purposes only and does not bind coverage. I understand the AHP gathers this information for statistical and actuarial uses only and it will not be used in connection with decisions or actions regarding employment.

_______**Initial** If I am a resident in Michigan, I do not have to provide information regarding height or weight, and that this in compliance with requirements for GINA. Let's discuss if we want to add height and weight to the form.

______ **Initial** That as a prospective member, I have the right to request restrictions on how my protected health information is used, and that the Plan is not required by law to grant this request, but if the request is granted, the Plan is bound by this agreement. I also understand that I have the right to revoke this consent in writing, except to the extent the Plan has already used or disclosed the protected health information in reliance upon my consent. I further understand that the Plan will notify me the member of any health or enrollment related changes that occur after signing this form, up to the effective date of coverage.

Client Privacy Notification

________**Initial** Any information, including non-public personal health information, such as name, address and social security number, including detailed protected health information provided will be used for the sole purpose of providing a risk assessment to the health plan the thus provide a health care benefit quote. The Plan's actuary is a legally contracted underwriter acting as a Business Associate to the Program and is subject to certain provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

regulations. The Plan's actuary and underwriter will not sell, license, transmit or disclose this information outside of their offices except as: a) necessary for them to provide the services on behalf of the health plan, b) implicitly authorized by you, c) necessary for backup documentation purposes, or d) required by law. As a pre-condition of Plan inclusion, prospective member agrees to contribute to the ongoing development of Population Health Management initiatives aimed at improving the health and wellbeing of the program.

Prospective Member certifies that the answers above are true for all seeking coverage.

Signature: ____ ***Date:*** _______________

Member & Dependent Information

PRIMARY MEMBER

Member Name:

Member EIN
Member Mobile:
Email:
Full Address:
Social Security Number:
Gender:
Date of Birth:
Height:
Weight:
Tobacco Use in Last Year?
Are you adding a Spouse/Domestic Partner?

SPOUSE/PARTNER

Spouse Name:

Spouse Social Security Number:
Spouse Gender:
Spouse Mobile #:
Pregnant?:
Spouse Date of Birth:
Spouse Height:
Spouse Weight:
Spouse Tobacco Use in Last Year?
Are you adding a Child?

CHILDREN

Child 1 Name:
Child Social Security Number:
Child Gender:
Date of Birth:
Child Height:
Child Weight:
Child Tobacco Use in Last Year?

Are you adding a Second Child?

Child 2 Name:
Child Social Security Number:
Child Gender:
Date of Birth:
Child Height:
Child Weight:
Child Tobacco Use in Last Year?

3rd Child etc.

EBA Health Plan Participation Agreement

Section 1 Billing & Collections

This initial Contract shall remain in force from the Effective Date of Coverage ("Effective Date") through Dec 31st of the year (the "Deductible Year") unless terminated pursuant to the terms and conditions contained herein. Unless otherwise agreed to in writing by Employers Business Alliance (the "Plan"), the Effective Date shall always be the first day of the month.

Any subsequent Contracts for Renewal of Coverage ("Renewal Contracts") shall remain in force for subsequent periods of twelve (12) months unless terminated by the Member or the Plan. Payment of money to cover the cost of Health Benefits shall be remitted to the Plan monthly, subject to the following guidelines for Billing and Collections:

1. Billing shall be based on the current census of Covered Participants that are on record with the Plan, as of the date on which invoices are generated. Member understands that any changes to their census may result in changes to their Maximum Funding Rates.

2. The Third-Party Administrator for the EBA Plan will bill approximately ten (10) days in advance of each month. The invoice is due the first of each month, considered late if not paid by the 10th of the month and subject to termination if not paid by the 15h of the month.

3. Unless notified otherwise by the Plan, Maximum Funding Rates shall be drafted via ACH on the first business day of each month from a Maximum Funding Rates Pull Account, which is a bank account designated by the Member for purposes of pulling Maximum Funding Rates. If insufficient monies are available in the Maximum Funding Rates Pull Account, the Member shall experience a suspension in the payment of claims. Suspension shall continue until the Member has enough monies to correct the delinquency, at which point the Member's account can be considered current.

4. Member agrees to reimburse the Plan for any claims incurred and or paid during any period of delinquency, including, but not limited to, additional expenses that may be assessed due to late and or non- payment.

5. Any Member that fails to remit payment on the 15th day of the then-current month shall be considered for termination from the Plan. If payment is received within 30 days of the original due date ("Grace Period"), then the Member's participation in the Plan may be reinstated without a break in coverage. All reinstatements are subject to review, potential re-rate and/or declination. At the Plan's discretion, any Member that is terminated from the

Plan for non-payment may resume participation in the Plan once the outstanding balance is paid in full, if reinstatement has been approved.

6. Members and dependent terminations must be sent to Member Services using the appropriate form(s) at least fifteen (15) days (“Minimum Notice”) prior to the requested date of termination. Member understands that any failure to provide this Minimum Notice will result in a termination delay, which will be no less than thirty (30) days. Member understands and agrees to remain liable for payment of Maximum Funding Rates for those experiencing a termination delay.

Section 2 Requested Effective Date

Member: Please indicate the month in which you would like for coverage from the Plan to begin. This date is a non-binding request that is contingent upon receipt of all quoting/enrollment materials and subject to the Plan’s acceptance of this Request/Contract. Once accepted, the Plan will provide notification of your actual Effective Date, **which shall only be on the first day of any given month.**

Requested Effective Date: _______________________

Section 3 Plan Type & Participant Coverage

Member: Please indicate the Coverage Type which you are electing.

Select One Only: ☐Self ☐Self + Spouse ☐Self + Children ☐Family

Member understands that only the signatory to this Contract is admitted as a Working Owner of EBA in return for a payment of $5.00 which is included in the monthly rate.

Member: Please indicate the Plan Type you are electing.

Plan		Deductible / Limits	Pharmacy
☐ **Plan #1 $500**	**Titanium**	**$500 Individual Deductible |$1,000 Family Deductible**	**Medalist RX (Integrated)**
☐ **Plan #2 $1,000**	**Diamond**	**$1,000 Individual Deductible |$2,000 Family Deductible**	**Medalist RX (Integrated)**
☐ **Plan #3 $1,500**	**Platinum**	**$1,500 Individual Deductible |$3,000 Family Deductible**	**Medalist RX (Integrated)**
☐ **Plan #4 $2,500**	**Gold**	**$2,500 Individual Deductible |$5,000 Family Deductible**	**Medalist RX (Integrated)**
☐ **Plan #5 $3,500**	**Silver**	**$3,500 Individual Deductible |$7,000 Family Deductible**	**Medalist RX (Integrated)**
☐ **Plan #6 $5,000**	**Bronze**	**$5,000 Individual Deductible |$10,000 Family Deductible**	**Medalist RX (Integrated)**
☐ **Plan #7 $7,350**	**Copper**	**$7,350 Individual Deductible |$14,700 Family Deductible**	**APS RX (Integrated)**
☐ **Plan #8 $2,500**	**HSA**	**$2,500 Individual Deductible |$5,000 Family Deductible**	**Medalist RX (Integrated)**
☐ **Plan #9 $3,500**	**HSA**	**$3,500 Individual Deductible |$7,000 Family Deductible**	**Medalist RX (Integrated)**
☐ **Plan #10 $5,000**	**HSA**	**$5,000 Individual Deductible |$10,000 Family Deductible**	**Medalist RX (Integrated)**
☐ **Plan #11 AC100**	**Limited Indemnity**	**$100,000 Annual | $500K Lifetime**	**APS RX (Integrated)**
☐ **Plan #12 AC250**	**Limited Indemnity**	**$250,000 Annual | $1.25M Lifetime**	**APS RX (Integrated)**
☐ **Plan #13 AC500**	**Limited Indemnity**	**$500,000 Annual | $2.5M Lifetime**	**APS RX (Integrated)**

FOR ALL PLANS THAT HAVE APS Rx as its Pharmacy: Please note that these plans include only a limited number of acute generic medications (127 in total) and that all chronic medications are mail-order. Members will pay out of pocket at a Retail Pharmacy for all acute or chronic medications that are not on the Plan Formulary.

Section 4 Rates & Contract Terms

Members seeking first-time coverage from the Plan ("New Working Owners") agree that rates assessed pursuant to Initial Contracts shall remain in force from the Effective Date through December 31st of the current year, unless otherwise modified by the Plan. New Working Owners shall be construed to include any Members that had previously lost coverage from the Plan as the result of any failure to remit payment before the end of the Grace Period. New Deductible Year rates will be presented one (1) month prior to the start of the calendar year.

Upon conclusion of an Initial Contract, Members may continue their coverage with the Plan for subsequent periods that are no less than twelve (12) months. Unless otherwise modified by the Plan, amounts assessed pursuant to Renewal Contracts remain valid from January 1st ("Renewal Date") until December 31st of the subsequent calendar year. Members that remit payment as due on the Renewal Date will be deemed to have accepted the Renewal Contract. Unless otherwise notified by the Plan, Members understand and agree that the terms and conditions of Renewal Contracts are the same as those in effect for the Initial Contract. Member agree the Plan reserves the right to adjust rates during Initial and or Renewal Contracts if the claims expense and or Plan utilization exceeds projections.

By signing this Request/Contract the Member agrees to all the terms and conditions contained herein.

Section 5 Termination & Cancellation

Member agrees that the Plan reserves the right to modify, terminate, or rescind this Request/Contract back to the original Effective Date if any employee intentionally provides the Plan with inaccurate information about their health or the health of their dependents during the underwriting process. Rescind means that the coverage was never in effect. Should this Request/Contract be rescinded, the Member agrees to accept liability for all claims that have been incurred by their employees or dependents of their employees but not paid.

Early cancellation (defined as those less than six (6) months of full healthcare contributions) carry a reservation of right by the Plan to apply all contributions paid toward Administrative Fees and reinsurance. Members that cancel coverage before their renewal forfeit their coverage under stoploss and runout. Only claims received before the cancellation date will be paid. Upon cancellation, any claims that have not been received by the Plan after the cancellation will be the sole responsibility of the participant, even when the date of service is prior to the cancellation date.

Section 6 Summary of Benefits & Coverage

The Patient Protection and Affordable Care Act has established many new requirements and standards for health plans, including the requirement to create and distribute a uniform Summary of Benefits and Coverage (SBC). The purpose of the SBC is to provide standard information and uniform language across the health benefits business to allow consumers to compare options and select health plans easily. All SBCs can be found by visiting your TPA website and searching "Plans".

Section 7 Underwriting Guidelines

Underwriting Guidelines, as established by the Plan, shall be enforced while all Initial and Renewal Contracts are in force and shall continue to do so unless the Employer/Group is notified otherwise by the Plan

By signing this Request/Contract, the Member agrees to be bound by the Plan's Underwriting Guidelines

Section 8 Conditions of Plan Coordination

The Plan shall exclude coverage for work-related sickness or injury eligible for benefits under workers' compensation, employers' liability, Own Occupation, Occupational Accident, or similar laws, even when the Covered Participant does not file a claim for benefits, or sickness or injury that arises out of, or is the result of, any work for wage or profit. This exclusion will apply to a Covered Participant who is not required to have coverage under any workers' compensation, personal liability or similar State or Federal law and does not have such coverage. Proof of waiver of coverage will be

required for those members eligible who waived or not enroll based on the State and/or Federal law.

Section 9 Conditions of Plan Participation

The following **Joinder Agreement** allows this member and dependents access to the ERISA health plan offered by Population Science Management LLC. It is important that the member understands in plain language, what membership entails:

1. As a Preferred Unit holder, the joinder and operating agreement **does not** expose the member to any financial or legal liability.
2. As a Preferred Unit holder, member agrees to participate when asked in activities to support our research in population science. Activities can include but not limited to short surveys, videos, and other interventions.
3. As a Preferred Unit holder in accordance with membership in the health plan, the member is required to participate in above mentioned activities for which they will be paid with funds placed on a debit/credit card.
4. Member understands and consents to the use of their deidentified data for research purposes.

INTIAL________Joinder Agreement

Reference is hereby made to the Limited Liability Company Agreement, dated May 19, 2023, as amended from time to time (the "LLC Agreement"), among the existing Members of Population Science Management LLC, a company organized under the laws of Tennessee (the "Company"). Pursuant to and in accordance with Section 5.01(b) of the LLC Agreement, the undersigned herby acknowledges that it has received and reviewed a complete copy of the LLC Agreement and agrees that upon execution of this Joinder, such Person shall become a party to the LLC Agreement and shall be fully bound by, and subject to , all the covenants, terms, and conditions of the LLC Agreement as though an original party thereto and shall be deemed, and is hereby admitted as, a Member for all purposes thereof and entitled to all the rights incidental thereto and shall hold the status of Participating member.

Capitalized terms used herein without definition shall have the meanings ascribed thereto in the LLC agreement.

SPOUSAL CONSENT

I, ___________________, spouse of _______________________, acknowledge that I have read or been given access to read the Operating Agreement, dated May 19th, 2023 by Population Science Management LLC, a Tennessee limited liability company (the "**Company**"), to which this Consent of Spouse (this "**Consent**") is attached as Exhibit B (as the same may be amended or amended and restated from time to time, the "**Agreement**"), and that I understand the contents of the Agreement. I am aware that my spouse is a party to the Agreement and the Agreement contains provisions regarding the voting and transfer of the Membership Interests (as defined in the Agreement) of the Company which my spouse may own, including any interest I might have therein.

I hereby agree that I and any interest, including any community property interest, that I may have in any Membership Interests of the Company subject to the Agreement shall be irrevocably bound by the Agreement, including any restrictions on the transfer or other disposition of any Membership Interests, valuation methods, or agreed values for the Membership Interests or voting or other obligations as set forth in the Agreement. I hereby irrevocably appoint my spouse as my attorney-in-fact with respect to the exercise of any rights and obligations under the Agreement. I agree that, in the event of divorce or the dissolution of my marriage to my present spouse or other legal division of property, I will transfer and sell, at the fair market value, to my spouse any and all interest I have or may acquire in the Company, and I further agree that a court may award such entire interest to my spouse as part of any such legal division of property. The foregoing agreement is not intended as a waiver of any community property or other ownership interest I may have in the Membership Interests of the Company, but only as an agreement to accept other property or assets of substantially equivalent value as part of any property settlement agreement or other legal division of property upon divorce or the dissolution of my marriage. I agree not to bequeath my interest, if any, in the Membership Interests of the Company, by will, trust, or any other testamentary disposition to any person other than my current spouse. Further, the residuary clause in my will shall not include my interest, if any, in the Membership Interests of the Company.] I agree not to pledge or encumber any interest I may have in the Membership Interests of Company.

This Consent shall be binding on my executors, administrators, heirs, and assigns. I agree to execute and deliver such documents as may be necessary to carry out the intent of the Agreement and this Consent. I am aware that the legal, financial, and related matters contained in the Agreement are complex and that I am free

to seek independent professional guidance or counsel with respect to this Consent. I have either sought such guidance or counsel or determined after reviewing the Agreement carefully that I will waive such right. I am under no disability or impairment that affects my decision to sign this Consent and I knowingly and voluntarily intend to be legally bound by this Consent. I am satisfied with the terms of this Consent and I understand and have received full disclosure of all the rights that I am agreeing to waive.
I hereby agree that my spouse may join in any future amendment, waiver, consent, or modification of the Agreement without any further signature, acknowledgment, agreement, or consent on my part or notice to me.

(Signing Spouse Name) ________________________________ Date ______________________

Initial________ I understand for my policy to remain in effect, my spouse is required to sign the spousal consent with this Joinder Agreement.

Spouse Email -______________________________

Member further agrees that:

1. For coverage to go into effect, the Member's Request/Contract must be accepted by the Plan.

2. For coverage by the Plan to remain in force, the Member must: (1) be an eligible Certificate Member of Employers Business Alliance ("EBA") LLC when applying for participation in this Plan; (2) meet membership requirements established by the governing documents of EBA, LLC; (3) remain a member in good standing of EBA, LLC

3. The Member has seen a copy of the benefits proposed and agrees to remit all applicable contributions to the Plan as outlined in Section Three (3).

4. At all times, the coverage is subject to the benefit plan applied for by the Member, which alone constitutes the Contract under which benefits become payable.

5. Member agrees that Plan shall not be liable for any health care claims incurred by any Covered Participant(s) and or Dependent(s) after the date on which coverage was terminated. Member agrees to reimburse the Plan for covered charges which were incurred by Covered Participant(s) and or Dependents(s) after the date of terminated coverage.

6. Member understands the plan reserves the right to ask for a current wage & tax statement to verify eligibility and a copy of a members Collective Bargaining agreement when and if applicable.

7. Member understands and agrees that the Plan may modify health care fees based on risk and/or utilization factors.

8. Member understands the plan reserves the right to ask for acceptance of this Request/Contract by the Plan is subject to the Member's willingness to be bound by the Plan's requirements. For purposes of this Section, these requirements include the provisions of any Administrative Services Agreement between the Plan and its TPA, but only to the extent, such provisions apply to rights and or obligations of Members participate in the Plan.

9. EBA is a platform designed and underwritten for self-employed individuals. By signing this form in Section 10, you represent that you are a self-employed. You further represent that you can provide proof of being self-employed. EBA reserves the right to request evidence from any member while participating in the health plan. Misrepresentation could result in removal from the plan and denial of claims.

Section 10 Member Attestation & Signature

Member hereby acknowledges and understands that (1) all enrolled Participants must meet all of the Plan's terms and conditions, outlined herein; and (2) absent a Qualifying Life Event, as defined in 26 CFR 1.125-4, participants and any of their respective dependents are not permitted to make changes until the next open enrollment period, as established by the Plan.

Member(s) accepts full responsibility that the information provided to the Plan regarding themselves and any of their respective dependents is accurate. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefits or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Member Name (Printed) ___________________________________

Member Signature ___________________________________ Date____________

Section 11 Broker Attestation & Signature

Broker certifies that these products have been explained to the client and the client understands the benefits and limitations. Broker also represents that applicant did not make any statements or ask questions that would be contrary to the answers given in both the Health Questionnaire and the Participation Agreement

Broker Name (Printed) ____

Broker Signature ______________________________________ Date ____________

Credit Card Merchant Required Language.

General Credit Card Authorization verbiage:
By signing below, you authorize [Your Organization] to charge your credit card ending in [last four digits of the credit card] for the total sum of [amount] as outlined in the agreement. This payment represents the initial monthly payment (choose applicable) required to secure coverage, as specified in the agreement terms.

Initial____________ If signing up for auto-pay, you authorize recurring scheduled charges to your credit card. You will be charged [amount] each [monthly]. I (we) understand that this authorization will remain in full force and effect until I (we) notify Detego Health in writing that includes account name, date of requested revocation that I (we) wish to revoke this authorization. I (we) understand that Detego Health requires at least [30 days] prior notice in order to cancel this authorization.

General ACH Authorization verbiage:
I (we) authorize ________________________ Detego Health to electronically debit my (our) account (and, if necessary, electronically credit my (our) account to correct erroneous debits) as follows:

Amount of debit(s): $__________
Start Date _____________
Frequency_____________

I (we) understand that this authorization will remain in full force and effect until I (we) notify Detego Health in writing that includes account name, date of requested revocation that I (we) wish to revoke this authorization. I (we) understand that Detego Health requires at least 30 days prior notice in order to cancel this authorization.

Select One:
❏ Checking Account
❏ Savings Account
at the depository financial institution named below (“DEPOSITORY”). I (we) agree that ACH transactions I (we) authorize to comply with all applicable law.
Depository Name ____________________________________
Routing Number _____________________________________
Account Number ____________________________________

Select One:
❏ Personal Account
❏ Business Account

Signature to authorize accordingly____________________________________

Date ______________