# DIRECT EMPLOYER
# WOMEN'S MIDLIFE & MENOPAUSE CARE AGREEMENT

**The Confidence Clinic, LLC d/b/a The Menopause Clinic**

Employer: _____ Effective Date: _____

## AGREEMENT AT A GLANCE

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| **Program** | Women's Midlife & Menopause Care |
| **Employer cost** | $99 per enrolled Member per month + $100 one-time enrollment fee |
| **Member cost** | $0 for covered clinical services |
| **Initial visit** | One comprehensive initial visit, in person or by video as clinically appropriate and legally permitted |
| **Follow-up visits** | Additional medically appropriate covered video and in-person follow-up visits included at $0 |
| **Between-visit care** | Secure asynchronous clinical access and treatment-plan review included |
| **Access standard** | Current-treatment clinical requests: clinical response generally within one business day during regular business hours |
| **Other turnaround standards** | New treatment requests: up to 3 business days; routine structured treatment reviews: up to 5 business days |
| **Outcomes** | Structured symptom/outcome measurement with aggregate, de-identified quarterly employer reporting when privacy thresholds are met |
| **Prior authorization** | None for covered clinical services |
| **Balance billing** | None for covered clinical services |
| **Term** | 12-month initial term; termination rights as stated in this Agreement |

## 1. PURPOSE

The purpose of this Agreement is to provide eligible employees and adult dependents ("Members") with direct access to longitudinal specialty care for perimenopause, menopause, sexual and genitourinary health, and selected preventive, cardiovascular, bone, metabolic, weight, and nutritional concerns common in midlife.

The program is designed to provide ongoing access to a menopause specialist rather than limiting care to isolated office visits. It combines longitudinal specialty care with structured outcomes measurement so treatment can be adjusted based on Member response and, when participation is sufficient to protect privacy, Employers can receive aggregate visibility into the impact and performance of the benefit. Provider is not intended to replace a Member's comprehensive primary care provider, emergency care, hospital care, or other specialty care.

## 2. PRICING

Employer will pay Provider $99 per enrolled Member per month, plus a $100 one-time enrollment fee for each new Member.

The rates stated in this Agreement constitute Provider's complete and exclusive schedule of charges to Employer for the program. Provider will not charge Employer an implementation, administrative, technology, platform, network-access, or intermediary fee unless separately agreed in writing.

There are no additional visit fees, message fees, or treatment-plan review fees for covered services. The monthly fee begins when the Member enrolls in the program.

Medications, laboratory testing, imaging, outside facility charges, and services provided by other healthcare professionals are not included.

Contracted rates under this Agreement are available only to self-funded employers or their authorized plan administrators that contract directly with Provider. These rates may not be used, accessed, rented, repriced, incorporated, or otherwise applied by commercial insurers, fully insured health plans, provider networks, PPO networks, network leasing organizations, or other third-party networks unless Provider expressly agrees in a separate written agreement.

## 3. ELIGIBILITY AND ENROLLMENT

Enrollment is voluntary. The program is available to eligible adult employees and adult dependents who are eligible under the Employer's plan, are physically located in a state in which Provider is authorized to provide the applicable care when services are rendered, and complete Provider's required enrollment, consent, and clinical documentation. Provider may make the program available in additional states as Provider obtains the professional licenses, registrations, controlled-substance authority, telehealth authority, and other approvals required by applicable law. Publication of this Agreement does not represent that Provider is currently accepting patients in every state.

Provider retains sole clinical discretion regarding whether any treatment, medication, diagnostic test, or service is medically appropriate.

## 4. INCLUDED CLINICAL SERVICES

### Perimenopause and Menopause Care

Comprehensive menopause and perimenopause evaluation; symptom and goal assessment; individualized treatment planning; hormone therapy evaluation; estradiol and progesterone/progestogen management; vaginal estrogen and other genitourinary treatments; nonhormonal treatment; medication adjustment and monitoring; and evaluation of treatment effectiveness and adverse effects.

### Testosterone and Sexual Health

When medically appropriate and legally permitted: evaluation of sexual desire and arousal concerns; testosterone candidacy assessment; prescribing, dose adjustment, laboratory monitoring, and ongoing management; required in-person assessment; and evaluation and treatment of genitourinary syndrome of menopause, vaginal dryness, discomfort, and painful intercourse.

Testosterone treatment is not guaranteed and is prescribed only when the treating clinician determines it is clinically appropriate.

### Cardiovascular, Metabolic and Preventive Health

Cardiovascular risk assessment; blood pressure review; lipid, diabetes, and metabolic risk assessment; review of personal and family cardiovascular risk factors; counseling regarding modifiable risk; age-appropriate preventive screening review; and appropriate testing or referral recommendations.

### Bone Health

Osteoporosis and fracture-risk assessment; review of accelerated bone-loss risk factors; bone-density screening recommendations; bone-health counseling; and referral or additional evaluation when indicated.

### Iron and Selected Nutritional Deficiencies

When clinically indicated: evaluation of iron deficiency; review of CBC, ferritin, iron studies, and related testing; evaluation of selected nutritional deficiencies that may contribute to midlife symptoms; and treatment recommendations and monitoring within Provider's scope.

**Weight and Metabolic Care**

Weight and metabolic health assessment; lifestyle and behavioral recommendations; evaluation of weight-related health risks; prescription weight-management treatment; GLP-1 evaluation, prescribing, dose management, and monitoring when clinically appropriate. Medication cost is not included.

## 5. COMPREHENSIVE INITIAL EVALUATION

Each new Member is eligible for one comprehensive initial visit, provided in person or by video as clinically appropriate and legally permitted. The initial visit is included in the membership and carries no additional visit charge. It may include detailed health and reproductive history, medication review, symptom assessment, cardiovascular and bone-health risk review, metabolic and weight assessment, preventive health review, sexual and genitourinary health assessment, review of relevant testing, individualized recommendations, and shared decision-making. Initial visits may be scheduled for up to approximately 60 minutes when clinically appropriate.

## 6. ONGOING ACCESS

Membership is designed for longitudinal care. Members may receive, as medically appropriate: secure clinical messaging; medication questions and adjustments; prescription and refill management; symptom assessment and structured tracking; treatment-plan reassessment; laboratory review; video follow-up; in-person follow-up; care coordination; and referral recommendations.

After the initial visit, additional medically appropriate covered video and in-person follow-up visits are included without an additional per-visit charge, along with covered secure clinical messaging and treatment-plan reviews. Services are provided according to clinical need and Provider availability. Nothing in this Agreement guarantees unlimited appointments, immediate responses, a particular treatment, or access to a clinician on demand.

## 7. ASYNCHRONOUS CARE

Secure asynchronous care is an important part of ongoing treatment. Members may submit symptoms, treatment responses, side effects, questions, and other clinical information electronically. Provider may evaluate this information and make treatment recommendations without a scheduled appointment when clinically appropriate and legally permitted.

Provider may require a video or in-person visit whenever the treating clinician determines one is necessary.

## 8. RESPONSE TIMES

Provider will maintain a one-business-day clinical response standard for applicable Member questions concerning current treatment during regular business hours. New treatment requests and new-treatment clinical forms are generally reviewed within up to three business days. Routine structured symptom assessments and treatment-plan review requests are generally reviewed within up to five business days.

Regular business hours are Monday-Friday, 9:00 a.m.-5:00 p.m. Central Time, excluding holidays and announced closures. The program does not provide 24-hour medical coverage.

## 9. IN-PERSON CARE

Provider maintains the ability to provide in-person care when clinically appropriate or legally required. Certain treatments, including controlled substances such as testosterone, may require in-person evaluation or monitoring. Members are responsible for completing required visits, laboratory testing, consent forms, and monitoring necessary for continued treatment.

## 10. CLINICAL INDEPENDENCE

All medical decisions remain exclusively between Provider and the Member. Employer, its health plan, third-party administrator, or other party may not require Provider to prescribe or withhold a treatment, require prior authorization for a covered clinical service, interfere with clinical decision-making, or require treatment inconsistent with applicable standards of care. Provider retains sole authority to determine medical necessity and clinical appropriateness.

## 11. NO PRIOR AUTHORIZATION FOR COVERED CLINICAL SERVICES

Provider will not require Employer or its health plan to approve individual clinical decisions for services included in the membership. This provision does not require Employer to pay for medications, laboratory testing, imaging, procedures, or other services outside the membership.

## 12. MEMBER COST

Employer will pay 100% of the contracted membership fee and enrollment fee unless otherwise required by applicable law or benefit-plan requirements. Provider will not balance bill Members for covered services. Members remain responsible for expenses not included in this Agreement.

## 13. SERVICES NOT INCLUDED

The membership does not include emergency medical care; general urgent care unrelated to Provider's scope; hospitalization; comprehensive general primary care; management of conditions outside Provider's scope; surgery; outside procedures; imaging; outside laboratory charges; pathology; medications; pharmacy charges; outside specialist fees; ambulance or emergency department services; behavioral health services outside Provider's scope; or any service not expressly included.

Members should maintain a primary care relationship and appropriate health insurance or other coverage for healthcare needs outside the program.

## 14. PRESCRIPTION MEDICATIONS

The membership includes clinical evaluation and prescribing when medically appropriate. Medication cost is not included. Provider may assist with identifying lower-cost pharmacy options but does not guarantee medication price, coverage, inventory, discounts, or availability.

Provider is not required under this Agreement to complete medication prior authorizations unless separately agreed in writing.

## 15. LABORATORY TESTING

Provider may order or recommend laboratory testing when clinically appropriate. Laboratory charges are not included unless expressly stated. Provider may make direct-pay testing options available, and Members may use laboratory benefits available through their health plan when permitted.

## 16. OUTCOMES MEASUREMENT & EMPLOYER REPORTING

Provider uses structured symptom and outcome tracking to evaluate treatment response over time rather than relying solely on visit utilization. Members may complete structured symptom assessments and other outcome measures at defined points during care. Provider uses these results to evaluate treatment response, identify areas requiring adjustment, and support individualized treatment decisions.

Within approximately thirty (30) days after each calendar quarter, and when participation is sufficient to protect individual privacy, Provider may provide Employer with an aggregate, de-identified program report. Reporting may include enrollment and engagement; utilization by modality; access and response-time performance; change in symptom burden; percentage of participating Members demonstrating meaningful symptom improvement; time to improvement; treatment engagement and continuation; Member-reported satisfaction; medication-access barriers; referral or care-coordination measures; and other agreed clinical or program-quality measures.

Where appropriate and agreed upon by the parties, aggregate reporting may also incorporate Member-reported measures related to the effect of symptoms on work and daily function, including absenteeism, presenteeism, productivity, or ability to perform usual activities.

Outcome measures are intended to support clinical quality improvement and evaluation of the program. They do not constitute a guarantee that any individual Member or enrolled population will achieve a particular clinical, functional, utilization, or workforce outcome.

Provider will not disclose an individual Member's participation, diagnosis, treatment decisions, medications, messages, laboratory results, outcome responses, or other individually identifiable health information to Employer except with the Member's authorization or as otherwise permitted or required by law.

## 17. PRIVACY

Provider will maintain Member information in accordance with applicable privacy laws. The employment relationship remains separate from the clinical relationship. Employer does not receive access to individual Member medical records merely because Employer pays the membership fee.

## 18. ELIGIBILITY DATA

Employer or its designated administrator will provide an updated eligibility roster at least monthly in a format reasonably specified by Provider and will timely notify Provider when a Member loses eligibility. New enrollment becomes effective after the Member completes required enrollment and is accepted by Provider, on the effective date communicated by Provider and Employer. Additions and terminations will be reflected on the next applicable monthly invoice or reconciliation. Provider is not responsible for errors resulting from inaccurate or delayed eligibility information.

## 19. BILLING AND PAYMENT

Provider will invoice Employer or its designated administrator according to the agreed enrollment roster and payment process. Payment is due within 30 days of receipt of a complete and accurate invoice or other agreed payment submission. Provider will not be required to collect the contracted membership fee from Members.

Provider may suspend new enrollment or terminate this Agreement for material nonpayment after reasonable written notice and an opportunity to cure.

## 20. NO MINIMUM ENROLLMENT; CAPACITY

Unless otherwise agreed in writing, Employer is not required to guarantee a minimum number of Members, and Provider is not required to reserve unlimited capacity. Publication of rates or contract terms does not obligate Provider to contract with every employer.

Provider may temporarily pause new Member enrollment when reasonably necessary to maintain clinical quality and access for existing Members.

## 21. MEMBER DISENROLLMENT AND CLINICAL TERMINATION

A Member may leave the program at any time. Employer will not be charged monthly membership fees for periods following the effective date of disenrollment, subject to the agreed billing cycle. The one-time enrollment fee is nonrefundable once onboarding or clinical review has begun.

Provider may terminate an individual clinical relationship when permitted by law, including for threatening or abusive behavior, fraudulent information, repeated failure to complete essential safety monitoring, unsafe prescribing circumstances, relocation outside Provider's authorized service area, or breakdown of the therapeutic relationship. Applicable patient-termination requirements will be followed.

## 22. TERM AND TERMINATION

The initial term is one year beginning on the Effective Date and automatically renews for successive one-year terms unless either party gives at least 30 days' written notice of nonrenewal.

Either party may terminate without cause upon 60 days' written notice. Either party may terminate for material breach if the breach is not cured within 30 days after written notice. Provider may suspend or terminate sooner when necessary to comply with law, licensing requirements, patient-safety obligations, or circumstances materially threatening safe clinical care.

## 23. RATE CHANGES

Provider may change contracted rates upon renewal by giving at least 60 days' written notice. No rate increase will take effect during the then-current annual term unless mutually agreed in writing.

## 24. LICENSURE AND PROFESSIONAL STANDARDS

Provider will maintain professional licenses, registrations, credentials, and professional liability coverage required by applicable law. Clinical services will be provided by appropriately licensed healthcare professionals acting within lawful scopes of practice.

## 25. SERVICE AREA AND MULTI-STATE AVAILABILITY

Provider currently offers services to Members located in Louisiana. Provider may offer services in additional states as Provider's clinicians become appropriately licensed and authorized to practice in those states. Provider may expand its service area over time, including by adding clinicians licensed in other states. Employer may request availability in additional states; however, Provider is not obligated to begin services in any state until all applicable licensing, prescribing, telehealth, controlled-substance, operational, and clinical-readiness requirements have been satisfied. Availability may therefore vary by state and by service.

## 26. MEMBER CHOICE

Nothing restricts a Member from obtaining healthcare from another clinician or facility or requires a Member to obtain treatment from Provider. The program is intended to expand access and choice.

## 27. NO GUARANTEE OF OUTCOME

Provider does not guarantee any particular clinical outcome, symptom response, medication, prescription, laboratory result, weight change, or treatment result. Care is individualized based on clinical information, risks, preferences, examination when applicable, and available medical evidence.

## 28. INDEPENDENT CONTRACTORS

Provider and Employer are independent contracting parties. Nothing creates an employment, partnership, joint venture, agency, or fiduciary relationship. Provider retains independent control over clinical operations and medical decision-making.

## 29. INSURANCE AND BENEFIT-PLAN STATUS

This Agreement provides access to specified healthcare services and is not intended to provide comprehensive health insurance coverage. Members should maintain appropriate health insurance or other financial arrangements for services outside the program.

Nothing in this Agreement is intended to characterize Provider as an insurer, health maintenance organization, or other risk-bearing entity.

## 30. HSA/HDHP AND OTHER BENEFIT COMPLIANCE

The parties acknowledge that federal requirements applicable to HSA-qualified high-deductible health plans and other employee benefit arrangements may affect the treatment of membership fees or services. Employer and its benefit-plan advisors are responsible for determining appropriate plan treatment. The parties will reasonably cooperate to administer the program consistently with applicable requirements.

## 31. COMPLIANCE WITH LAW

Each party will comply with applicable federal and state laws relating to its responsibilities. If a change in law materially affects the program, the parties will cooperate in good faith to modify the Agreement as reasonably necessary. Provider is

not required to provide any service or financial arrangement that Provider reasonably determines would violate law, licensing requirements, professional standards, or regulatory requirements.

## 32. ASSIGNMENT

Neither party may assign this Agreement without written consent of the other, except as part of a merger, reorganization, sale of substantially all relevant assets, or successor transaction in which the successor assumes the assigning party's obligations.

## 33. ENTIRE AGREEMENT; AMENDMENT; SEVERABILITY

This Agreement and incorporated exhibits constitute the entire agreement concerning the services described. Amendments must be in writing and agreed to by both parties. If any provision is invalid or unenforceable, the remaining provisions remain effective to the fullest extent permitted by law.

## 34. NOTICES

Formal notices to Provider: The Confidence Clinic, LLC d/b/a The Menopause Clinic, New Orleans, Louisiana. Notices may be delivered to Provider's designated contracting contact or to other written contact information supplied to Employer at execution.

Formal notices to Employer: Notices will be delivered to the contracting representative, mailing address, and email address designated by Employer at execution.

## 35. GOVERNING LAW

This Agreement is governed by the laws of the State of Louisiana, except to the extent federal law applies.

## 36. ELECTRONIC SIGNATURES

Electronic signatures and counterparts have the same force and effect as original signatures.

## EXHIBIT A - EMPLOYER RATE & SERVICE SUMMARY

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| **Monthly membership** | $99 per enrolled Member |
| **One-time enrollment fee** | $100 per new Member |
| **Member charge for covered clinical services** | $0 |
| **Covered access** | Initial evaluation, secure messaging, treatment-plan review, medication management, lab review, and video or in-person follow-up when appropriate. Services may be offered in Louisiana and additional states where Provider is authorized to practice. |
| **Core clinical areas** | Menopause/perimenopause; sexual and genitourinary health; testosterone management when appropriate; cardiovascular and metabolic risk; bone health; preventive screening review; iron/selected deficiencies; weight and GLP-1 management |
| **Not included** | Medication cost, outside labs, imaging, hospital/emergency services, outside specialists, outside procedures, and care outside Provider's defined scope |
| **Outcomes measurement** | Structured symptom and treatment-response tracking with aggregate, de-identified employer reporting when participation is sufficient to protect privacy; may include symptom improvement, time to improvement, engagement, satisfaction, access measures, medication-access barriers, and agreed workforce-impact measures. |
| **Initial visit** | One comprehensive initial visit, in person or by video as clinically appropriate and legally permitted; included at $0 additional charge |
| **Follow-up visits** | Additional medically appropriate covered video and in-person follow-up visits included at $0 additional charge |
| **Clinical response standard** | Current-treatment clinical requests generally within one business day; new treatment requests up to 3 business days; routine structured treatment reviews up to 5 business days |
| **Employer reporting** | Quarterly aggregate, de-identified utilization, access, and outcomes reporting when participation is sufficient to protect privacy |

## SIGNATURES

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| THE CONFIDENCE CLINIC, LLC<br>d/b/a THE MENOPAUSE CLINIC<br><br>By: _____<br><br>Name: _____<br><br>Title: _____<br><br>Date: _____ | EMPLOYER<br><br>Company: _____<br><br>By: _____<br><br>Name: _____<br><br>Title: _____<br><br>Date: _____ |