Dear UEBT Member:

For: Currently Enrolled Blue Shield PPO Members and Spouses/Domestic Partners Who Wish to Participate in the UEBT Wellness Program (which is sometimes referred to as “Health Care Partnership” or “HCP”) in 2019.

If you are a current Kaiser HMO Member: PLEASE DO NOT USE THIS FORM

A BIOMETRIC SCREENING IS REQUIRED TO BE COMPLETED BY ALL MEMBERS (REGARDLESS OF CURRENT WELLNESS PROGRAM, OR HCP PARTICIPATION) FOR ENROLLMENT IN THE UEBT WELLNESS PROGRAM (HCP), FOR THE 2019 PLAN YEAR.

The UEBT wellness program (HCP) has reduced dependent premiums and out-of-pocket costs for doctor visits, hospital stays, etc. If you would like to be eligible to enroll in the UEBT wellness program (HCP) for 2019, you and your Spouse/ Domestic Partner must complete Action Steps, including a Biometric Screening. All eligible Members, including those currently enrolled in UEBT wellness program, must complete Action Steps for enrollment in the UEBT Wellness program in 2019. You do not have to wait until Open Enrollment to complete and submit your Biometric Screening. If you are planning an annual physical with your Primary Care Physician, you can simply take the attached HM7 form (or download the HM7 form from the Trust Fund website at www.ufcwtrust.com) and have your physician complete and fax the form to (650) 326-6700 before September 28, 2018. Additionally, once Open Enrollment begins, alternative options to complete your Biometric Screening (and other required Action Steps for participants who wish to be eligible for the UEBT wellness program (HCP) will be available. Information regarding Open Enrollment will be sent out in July.

Instructions:

Your physician biometric screening form will allow your doctor to perform your biometric wellness screening for the 2019 Plan Year. To use this screening option, laboratory results must be received by MedExpert by September 28, 2018. Please be aware, your physician may send you to an outside laboratory for biometric testing. You are responsible for ensuring your doctor timely faxes the form directly to MedExpert, complete with all screening values and signatures. Results received in any other format will not be accepted. Please follow these steps carefully:

1. Schedule an appointment with your doctor. If you have already had your annual physical for the 2018 Plan Year (meaning, you had your physical on or after January 1, 2018), your physician record your biometrics on the attached form and fax it to (650) 326-6700. Please be aware that your physician’s office may charge you a fee for a second physical as the Trust Fund will only cover one physical at 100% per calendar year. In addition, your physician may apply a fee for completing the form. If your physician
charges a fee for completing the form, please ask your physician’s office to submit the bill for the fee to Blue Shield’s address shown on the back of your health plan ID card.

2. Provide your Physician the “HM7 Physician Biometric Screening” form. **Your Physician must complete the “Physician Office Completes” section of the form, including signature, date, and UPIN/NPI.** The UPIN/NPI is a unique number that identifies your Physician’s office; your Physician will know this number.

3. **You must sign and date the “Participant Signature” area section of the enclosed Physician Biometric Screening Form before providing the form to your doctor.** NOTE: Participants and Spouses/Domestic Partners must each provide a separate form to their physician.

4. It is recommended you fast (not eat or drink anything but water) for at least 12 hours prior to your appointment. Continue taking medication as directed and be sure to drink plenty of water. Lab work must be completed between January 1, 2018, and September 28, 2018.

5. Your physician must fax the completed form to MedExpert at (650) 326-6700 by September 28, 2018. You are responsible for ensuring your Physician returns this form on or before September 28, 2018.

Only completed forms will be processed. If a form is submitted with missing information, you will be required to complete the entire form and resubmit, so please ensure that all items are filled out.

**General Information.** A federal law (the Genetic Information Nondiscrimination Act of 2008 or “GINA”) generally prohibits employers from requesting or requiring genetic information of an individual or that individual’s family members. However, final rules issued by the Equal Employment Opportunity (EEOC) provide that employers and sponsors of health plans may offer limited financial inducements (also called incentives or rewards) in exchange for an employee and his/her spouse/domestic partner providing information about his or her current or past health status as part of a wellness program, if certain conditions are met. The rules for spouses are somewhat different than for employees, in that the employee only needs to be informed of his/her rights with regard to the collection of genetic information, but for spouses, additional requirements need to be met. Specifically, the UFCW & Employers Benefit Trust (“UEBT”) is permitted to request information about the current or past health status of a member’s spouse/domestic partner who is completing the Health Risk Questionnaire (HRQ) and/or completing a Biometric Health Screening on a voluntary basis, provided that: (i) the spouse/domestic partner provides prior, knowing, written and voluntary authorization for the UEBT to collect genetic information and (ii) inducements in exchange for this information are limited. Therefore, if you are a spouse/domestic partner of a member, you will be asked to authorize your physician to provide, and for UEBT to collect, this information.

You are not required to complete the HRQ or do the blood test or other medical examinations, which are sometimes referred to as biometric screenings. However, only those members who do so will receive the benefits of participating in the UEBT wellness program (HCP). Specifically, members and (if applicable) enrolled spouses/domestic partners who choose to participate in the wellness program will receive incentives of lower deductibles, lower dependent premiums and, for participants in the PPO, a contribution to their Health Reimbursement Account which helps these members pay their family’s medical deductible, medical coinsurance and preferred prescription drug copays. In order for married members (or members in a domestic partnership) who have enrolled their spouse/domestic partner in the UEBT Plan to be eligible to participate in the wellness program, both the member and the spouse/domestic partner must complete the necessary steps, which will include an HRQ and/or a biometric screening.

The information from your HRQ and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks. The information may also be used to offer you assistance through online informational programs or personalized service through the PPO Individual Medical Decisions System (IMDS, for PPO Members only). You also are encouraged to share your results or concerns with your own doctor.
Additional incentives may be available for members or enrolled spouses/domestic partners who are identified by and participate in the Disease Management Program, which is another wellness program sponsored by the UEBT. If you are identified by and asked to enroll, but do not choose to participate in, the Disease Management Program, you could be subject to disincentives. If you are unable to participate in any of the health-related activities required by either the Plan’s wellness program (HCP) or the Disease Management Program, or achieve any of the health outcomes required to earn an incentive under the Disease Management Program, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Health and Welfare Services Department at (800) 552-2400.

**Protections from Disclosure of Medical Information**

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness programs and UEBT may use the aggregate information they collect to design a program based on identified health risks in the workplace, the wellness programs will never disclose any of your personal information either publicly or to your employer, union or the UEBT, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the UEBT wellness program or the Disease Management Program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness programs will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness programs, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness programs or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of a wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information will be MedExpert for PPO Members in order to provide you with services under the UEBT wellness program. In addition to MedExpert, PPO Member data is also reviewed by Sharecare in order to provide you services under the Disease Management Program.

For more information regarding this form or your other upcoming Action Steps (the Biometric Screening is considered an Action Step), please visit ufcwtrust.com or call MedExpert at 1-800-999-1999.

**If you have questions about the Biometric Health Screening, eligibility or enrollment in medical plan benefits, please contact the Trust Fund Office. Receipt of this notice does not constitute a determination of your eligibility for benefits.**
Important: This form is ONLY for current UEBT Blue Shield PPO members and spouses/domestic partners who are electing the UEBT wellness program, Health Care Partnership (HCP) plan (PPO or Kaiser HMO) for 2019 benefits.

By submitting this form, I am authorizing my physician to report the laboratory and biometric results to MedExpert for my Biometric Health Screening, and for UEBT to collect such information. If I am a Participant in the UEBT Plan because I am the spouse of a Member, I further acknowledge that by agreeing to this authorization, I am providing information regarding my current or past health status (or manifestation of disease or disorder) and that I authorize the use of this information for the purposes described in the previous pages.

- You are responsible for ensuring your doctor returns this form by the deadline.
- For an individual participant, only one physician form can be submitted.
- See the Action Steps flyer in your enrollment materials for more details.
- Please retain a copy of this physician-completed form for your records. You are responsible for ensuring your Physician returns this form to MedExpert.

Participant’s Signature: ___________________________ Date: _______ _______ _______
GENERAL INFORMATION

Participant Last Name: ____________________________
DOB: _______ • _____ • _______ (Month) (Day) (Year)

Note: Facility and agent name must be printed in the boxes.

Facility Name: ____________________________
Certifying Agent First Name: ____________________________
Last Name: ____________________________
NPI#: ____________________________

Today’s Date: _______ • _____ • _______ (Month) (Day) (Year)

I certify these values are correct

Blood Pressure

Systolic ____________________________
Diastolic ____________________________

Cholesterol

HDL: ____________________________
LDL: ____________________________
TRI: ____________________________
Total: ____________________________
Total/HDL Ratio: _______ • _______

Glucose

Fasting: ____________________________
A1c: ____________________________

For PROVIDER OR OFFICE STAFF USE ONLY BELOW THIS LINE

BMI: ____________________________
Blood Pressure: ____________________________
Cholesterol: ____________________________
Glucose: ____________________________

Body Measurements

Height: _______ (in) ____________________________
Weight: _______ (lbs) ____________________________
Waist: _______ (in) ____________________________

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Test Date: _______ • _____ • _______ (Month) (Day) (Year)

Tracking Number ____________________________

NOTE: Facility and agent name must be printed in the boxes.

I certify these values are correct

Facility Name: ____________________________
Certifying Agent First Name: ____________________________
Last Name: ____________________________
NPI#: ____________________________

Today’s Date: _______ • _____ • _______ (Month) (Day) (Year)

Signature: ____________________________

NOTE: Use area below for office or facility stamp

For more information, call the Healthy Measures Help Line at 1-800-999-1999

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