

WELLNESS Program Guide

2019

This guide contains step-by-step **instructions** needed to complete this year's **wellness program**. Please read through it carefully and complete all necessary steps by **April 30, 2019** to **avoid a \$50 per month surcharge for non-participation**.

Program Incentive

Participants in the wellness program are eligible to **avoid a \$50 surcharge** by taking a few simple steps to better understand their health:

- ✓ Complete Registration and Consent Form
- ✓ Complete Proof of Annual Physical Form

Once all required action steps are completed, participants will **avoid a \$50 surcharge per month** beginning **July 1, 2019**.





Welcome to your 2019 Wellness Program. You must complete Steps 1 – 3 below by **April 30, 2019** to **avoid a \$50 surcharge per month**.

Steps to Avoiding a \$50 Surcharge per Month

Complete the requirements below by the designated deadline to avoid a \$50 surcharge.

IMPORTANT! New Hire Requirements

Employees hired **before January 1, 2019** must complete the program in order to avoid the \$50 surcharge.

Employees hired **on or after January 1, 2019** will be grandfathered into the wellness rate.



STEP 1: Registration and Consent Form

Complete the Registration and Consent Form in its entirety and submit it to forms@wellworksforyou.com to earn credit for this step.



STEP 2: Proof of Annual Physical Form

Complete an annual physical exam with your physician between **May 1, 2018** and **April 30, 2019**. Take this packet with you to your appointment and have your doctor complete and sign the Proof of Annual Physical Form. It is the participant's responsibility to return the form as part of the completed packet (see Step 3 below) by **April 30, 2019**.

- ✓ Have you already received your annual physical within the above timeframe? Take this packet to your physician's office to have the Proof of Annual Physical Form completed.

If you do not have a doctor, you can select a doctor within the SCEC Consortium health benefit plan network. If you need assistance in finding a physician, please go to www.uhc.com. Little clinics and minute clinics do not qualify as Primary Care Visit completion.



STEP 3: Submit Your Completed Packet by April 30, 2019

Submit your completed packet in its entirety in one of three ways:

- ✓ Scan and email to: forms@wellworksforyou.com
- ✓ Secure fax to: **484.887.2223**
- ✓ Mail to: **1615 West Chester Pike, Suite 104**
West Chester, PA 19382
Attention: Forms Department

Keep a copy of all forms for your files. We will notify you when your packet has been processed. **Please allow 7-10 business days for processing.**



**Avoid \$50 per
month Surcharge**

QUESTIONS? Please contact **Wellworks For You** at **800.425.4657**.



registration and consent form

FOR WW OFFICE USE

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Complete the information below to register for participation in the wellness program. **If both the employee/retiree and spouse are eligible and choose to participate, a separate form must be completed for each.** Your signature is required at the bottom of the form to confirm you have read and understand what is involved in participating in the wellness program.

PLEASE PRINT CLEARLY

Contact Information

Company Name: SCEC Consortium

First Name: _____ Last Name: _____

Previous/Maiden Name (if changed in the last 12 months): _____

Date of Birth: _____ ☐ Male ☐ Female

Select One: I am the: ☐ Employee/Retiree ☐ Spouse

If you chose "Employee" above, type spouse's name here: _____

If you chose "Spouse" above, type employee's name here: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Participation Acknowledgement

I understand that initiating a follow-up examination to confirm results of any physical screening and obtaining professional medical assistance is my responsibility alone and not that of my health plan, employer (or spouse's employer/health plan) or Wellworks For You.

Wellworks For You will disclose to my (or my spouse's) employer that I had a physical and underwent laboratory testing. Wellworks For You will make this disclosure in order for my (or my spouse's) employer to determine eligibility for incentives.

My (or my spouse's) employer will not have access to any of my specific medical information provided through the Wellness Program. My employer and/or health plan - or my spouse's employer/health plan - will have access only to aggregate data to assess population trends ("Aggregate data" does not personally identify me but combines my individually identifiable medical information with those of other participants in the wellness program for review). Through my participation in the program, I consent to all of the following:

- ✓ Receipt of aggregate data as described in the previous paragraph by my health plan's/employer's or my spouse's employer/health plan
- ✓ Receipt of such aggregate data by my health plan/employer - or my spouse's health plan/employer - wellness advisor, USI Insurance Services LLC, and USI Holdings Corporation ("USI")
- ✓ Disclosure of my personally identifiable biometric data/report by Wellworks For You to the third-party data analytic vendor specified by my health plan/employer - or my spouse's health plan/employer - in order for such vendor to determine my eligibility for medical insurance premium discounts and/or for data aggregation as described above in this form

I affirm that I have read, understand, and agree to the terms set forth above, and I wish to participate in the Wellness Program on the terms specified.

Signature of Participant (Required)

Date



proof of annual physical visit

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Take this form with you to your scheduled annual physical exam to be completed and signed by your primary care physician. It is the participant's responsibility to submit the Annual Physical Proof of Visit Form as part of the wellness program to be returned to Wellworks For You as outlined below.

Patient Contact Information

Company Name: SCEC Consortium

First Name: _____ Last Name: _____

Date of Birth: _____ ☐ Male ☐ Female

Phone: _____ Email: _____

Physician Information

Physician Office/ Name: _____

Office Phone/Address: _____

Date of Visit: _____

This **Proof of Visit Form** confirms that the patient named above received the following preventative care between **May 1, 2018** and **April 30, 2019**.

GENERAL

- ☐ **Annual Preventative Exam** (physical performed by Primary Care Physician)
- ☐ **Bloodwork** (Age appropriate if recommended by Physician)

Physician

I certify that the patient listed above received the tests indicated on this form on: ____/____/____

Physician Signature: _____ Date Signed: _____



submit your forms

FOR WW OFFICE USE

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Once you have completed all of the requirements for the wellness program, submit the completed packet to Wellworks For You.

Choose one of the submission methods below:

- ✓ Scan and email to: forms@wellworksforyou.com
- ✓ Secure fax to: [484.887.2223](tel:484.887.2223)
- ✓ Mail to: [1615 West Chester Pike, Suite 104](#)
[West Chester, PA 19382](#)
[Attention: Forms Department](#)

Keep a copy of all forms for your files. We will notify you when your packet has been processed. **Please allow 7-10 business days for processing.**



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Month Surcharge**

QUESTIONS? Please contact [Wellworks For You](#) at [800.425.4657](tel:800.425.4657).



SCEC Consortium's Wellness Program is a voluntary wellness program available to all employees and spouses covered by the medical plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a proof of annual physical form. You are not required to participate, however, employees and spouses covered by the medical plan who choose to participate in the wellness program will avoid a \$50 per month surcharge for completing and submitting the Registration and Consent Form and Proof of Annual Physical Form.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Wellworks For You at 800-425-4657.

The information from your physical will be used to provide you with information to help you understand your current health and potential risks. You also are encouraged to share your results or concerns with your own doctor.

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 program and SCEC Consortium may use aggregate information it collects to design a program based on identified health risks in the workplace, Wellworks For You will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program 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 program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are the Wellworks For You team in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Wellworks For You at 800-425-4657.