Move Your Life in a Healthy Direction *and realize the rewards!*

Why Take Part in Healthy Directions?

City of Burnet cares about your health and wants to provide you with resources to help you live better both inside and outside of work. That's why we offer a voluntary wellness program for **all employees, spouses and retirees on the medical plan** called **Healthy Directions**, administered by TriHealth.

Program Incentive

Participants (employees, spouses and retirees on the medical plan) in Healthy Directions earn a discount on their health insurance premiums by taking a few simple steps to better understand their health, including scheduling an annual physical with their primary care physical (PCP). Once all required action steps are completed, participants will receive a **20% discount on your City paid employee/retiree health insurance premium which ultimately results in a 0% employee/retiree contribution.**

NEW HIRES: If a new employee is on benefits on or before 2/1/18, they must comply with the wellness incentive program. If a new employee is on benefits 2/2/18 or later they will automatically receive the 2018 discount rate.

Primary Care Physician (PCP)

Establishing a relationship with your primary care physician, someone familiar with your medical history and able to coordinate all aspects of your care, is an essential part of the Healthy Directions program. Together, you and your physician determine how best to improve your overall wellbeing.

Please note that City of Burnet will not have access to any specific, personally identifiable health information through Healthy Directions.

Program Participation

This packet contains complete instructions and the forms needed to help you get started with Healthy Directions. Please read it carefully and complete all steps necessary to earn your health premium discount.

Questions?

Email: healthydirectionspcp@trihealth.com

Call: | 866 256 9007

Action Steps for Participation

- Complete and sign the Registration & Consent Form.
- Complete and sign the Authorization of Use and Disclosure of Protected Health Information Form
- Have an annual preventive physical with your primary care physician.
- Complete a standard lab-test blood draw that identifies biometric measures such as your cholesterol, glucose and triglyceride levels.
- Complete one age and gender specific screening.
- Receive a 20% discount on your City paid employee/retiree health insurance premium beginning Oct. 1, 2018.

Enrollment Deadline

Participants in the TriHealth Healthy Directions Wellness Program must complete the necessary steps by **6/30/2018** and submit the completed packet by **7/15/2018.**

TriHealth Healthy Directions

TriHealth.com

Welcome to Healthy Directions!

City of Burnet's wellness program administered by TriHealth

Steps to Earning Your Healthcare Premium Discount

A Complete and sign the Registration & Consent Form *

* Required to receive your healthcare premium discount

B Complete and sign the Authorization of Use and Disclosure of Protected Health Information Form*

* Required to receive your healthcare premium discount

C Schedule an annual preventive physical with your doctor

- Your physical must occur between **July 1, 2017–June 30, 2018**. Take your Healthy Directions packet with you to your appointment and have your doctor complete and sign the Biometric Measures & Physical Confirmation. It is the participant's responsibility to return the form as part of the completed packet by **July 15, 2018**. (See Step E below.)
- Have you already received your annual preventive physical within the above timeframe? Take your Healthy Directions packet to your physician's office to have the Biometric Measures & Physical Confirmation Form completed.
- NEW HIRES: If a new employee is on benefits on or before 2/1/18, they must comply with the wellness incentive program. If a new employee is on benefits 2/2/18 or later they will automatically receive the 2018 discount rate.
- If you do not have a doctor, you can select a doctor within the City of Burnet health benefit plan network. If you need assistance in finding a physician, please go to www.swhp.org.

D Complete One Preventive Screening

- Your preventive screening must occur between **July 1, 2017–June 30, 2018**. A list is provided on form D. Please take your form with you to your appointment and have the healthcare provider date and sign the Preventive Screening Confirmation Form.
- This form must be completed by the doctor completing the exam or TriHealth will be unable to accept it.
- Note: some tests your physician recommends may require an out-of-pocket expense; please check with your insurance carrier first to verify coverage.

E Submit your completed packet by 7/15/2018

- Submit completed packet in its entirety in one of three ways:
  - ❖Scan and email to healthydirectionspcp@trihealth.com
  - ❖Secure fax 513 852 3166
  - ❖Mail to Healthy Directions, 11129 Kenwood Road, Cincinnati, OH 45242
- Keep a copy of all forms for your files. We will notify you when your packet has been processed. Allow 7-10 business days.

A + B + C + D + E = Healthcare Premium Discount

Questions about the process?

Please contact healthydirectionspcp@trihealth.com or call **866 256 9007**.

Healthy Directions Registration & Consent A

PLEASE PRINT CLEARLY

Complete the information below to register for participation in Healthy Directions. **A separate form must be completed if both an employee/retiree and spouse choose to participate. *Your signature is required at the bottom of the form** to confirm you have read and understand what is involved in participating in Healthy Directions.

Employer: **City of Burnet**

First Name: _____ Last Name: _____

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

Date of Birth: _ _/_ _/_ _ _ _ Select One: ☐ Male ☐ Female

Select One:

☐ I am the Employee/Retiree: Do you have a spouse on your City of Burnet medical plan?

If yes, provide spouse's name: _____

☐ I am the Spouse of Employee/Retiree:

Please provide name of City of Burnet's employee: _____

Home Address: _____ City: _____

State: _____ Zip Code: _____ Preferred Phone: ____-____-_____

Preferred Email: _____

Healthy Directions Program Participation Acknowledgement

My participation in the Healthy Directions Program (the "Program") is voluntary. I understand that the responsibility for initiating a follow-up examination to confirm results of any physical screening or obtain professional medical assistance is mine alone, and not that of my (or my spouse's) Employer or Bethesda Healthcare, Inc./TriHealth, Inc ("TriHealth"). For purposes of this consent, "my Employer" means the entity (a health plan or my or my spouse's employer, as applicable) listed on the "Employer" line above.

I understand, agree and consent to the following:

- ✓ In order to be eligible for any medical insurance premium discounts or incentives offered under the Program by my Employer, I must have a physical, undergo laboratory testing (blood work) ("Eligibility Requirements"). My physician will complete the "Biometric Measures & Physical Confirmation" form included in this packet and the biometric screening results and other medical information contained on form will be disclosed to TriHealth by my physician. TriHealth will use the information on the Biometric Data Form to inform my Employer or my health insurer whether I completed the Eligibility Requirements. If I fail to complete any of the forms required for the Program, TriHealth has the right to tell my Employer which forms I have not completed in order for my Employer to follow up with me directly if it so chooses.
- ✓ My Employer will have access to and will review aggregate data (my individually identifiable medical information combined with those of other participants in the Program that does not personally identify me) to assess population trends. Such aggregate data may also be received by my Employer's designated wellness advisor or broker.
- ✓ Questions about your manifestation of a disease or disorder (that is, your medical history) may be considered genetic information. You do not need to answer these questions. As long as you complete all the other the requirements for participation in the wellness program, you will qualify for the Program reward/incentive even if you choose not to answer the questions which may be considered as requesting genetic information. In other words, you may choose not to answer the questions about your medical history and still qualify for the Program reward/incentive.
- ✓ Should you choose to answer the questions regarding your medical history, you are providing those answers voluntarily and you knowingly consent to the collection of that information. All of your personally identifiable health information collected as part of the Program, including any information that may be considered genetic information will be used for the purposes and in the manner described above and will be subject to the restrictions on its disclosure as described above.
- ✓ I understand that the cost of the physical and laboratory testing (blood work) is not covered by the Program. I may have cost sharing obligations (e.g. co-insurance; deductible) for the physical, the testing required for the Biometric Measures & Physical Confirmation Form and for any other tests ordered by my physician as a result of the physical.
- ✓ I received, read, and understand the "U.S. Equal Employment Opportunity Commission Notice Regarding Wellness Program" contained in this packet.
- ✓ **I read, understand and agree to the terms set forth above, have completed and signed the enclosed authorization and I wish to participate in the Program on the terms specified.**

SIGN _____ _____

* Signature of Participant (**Required**) *Date

Healthy Directions Authorization of Use and Disclosure of Protected Health Information

B

PLEASE PRINT CLEARLY

A separate form must be completed if both an employee/retiree and spouse choose to participate. ***Your signature is required at the bottom of the form** to confirm you have read and understand what is involved in participating in Healthy Directions.

Participant's Name	Employer City of Burnet
Date of Birth	Preferred Phone Number
Preferred E-mail address	

1. **Authorization**: I authorize TriHealth, Inc./Bethesda Healthcare, Inc. ("TriHealth") to use and/or disclose my individually identifiable health information as described below. TriHealth is engaged by my (or my spouse's) employer or employer sponsored health plan to provide services for the voluntary wellness program called Healthy Directions (the "Program"). My employer/spouse's employer or employer sponsored health plan, as applicable, is referred to in this authorization as "my employer."
2. **Type of Information to be Released:** I want the following information to be used and disclosed pursuant to this Authorization —
   - ✓ Medical information that I provide directly to TriHealth, including results from a health risk assessment.
   - ✓ Medical Information contained on the Biometric Measures & Physical confirmation form completed by my physician
3. **Your Refusal to Sign this Authorization:** TriHealth may not condition treatment or health plan enrollment or eligibility for benefits on whether or not you sign this Authorization. If you refuse to sign this Authorization TriHealth will not withhold treatment from you nor will the Employer or Insurance Company condition health plan enrollment or eligibility for benefits.
4. **Purpose for the Use or Disclosure:** The purpose for the use or disclosure is for:
   - ✓ My employer or for the health insurance company with whom my employer has coverage, to make individualized medical insurance premium discounts determinations or other incentive eligibility determinations.
   - ✓ TriHealth to create and report aggregate information (i.e. my data combined with those of other participants that does not personally identify me) back to my employer or my employer's designated wellness advisor/broker for population trending and program planning purposes.
   - ✓ A data analytics vendor specified by my employer to create and report aggregate (i.e. my data combined with those of other participants that does not personally identify me) back to employer for population trending and program planning purposes.
   - ✓ For a successor wellness vendor engaged by my employer to continue the ongoing administration of the wellness program offered by my employer if TriHealth is no longer engaged by my employer.

   No biometric measures/individually identifiable medical information (e.g. results of blood work) created or received by TriHealth in connection with the Healthy Directions Program will be shared with my employer.
5. **Re-disclosure:** I understand that the information used and/or disclosed pursuant to this Authorization may be re-disclosed by the recipient of the information and may no longer be protected by Federal law.
6. **Revocation:** I understand that I may revoke this Authorization at any time by notifying TriHealth in writing by sending a letter to the address of TriHealth, Inc., 11129 Kenwood Road, Cincinnati, Ohio, 45242, addressed to the Coordinator of the Healthy Directions Program. I understand that if I revoke this Authorization, it will not affect any actions that TriHealth took before it received my revocation letter.
7. **Expiration:** This Authorization will expire two years after the date below.

SIGN

_____ _____

* Signature of Participant (**Required**) *Date

Biometric Measures & Physical Confirmation

C

Take this form with you to your scheduled annual physical to be **completed and signed by your Primary Care Physician**. It is the participant's responsibility to submit the Biometric Measures & Physical Confirmation form as part of the complete packet to be returned to Healthy Directions as outlined below.

Employer Name: **City of Burnet**

Participant Name: _____ Date of Birth: _____

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

Preferred Phone: _____-_____-_____ Preferred Email: _____

PHYSICAL CONFIRMATION

Type of Service Provided: **Complete Annual Preventive Physical** Date of Service: ____/____/_____

_____ _____

***Signature of health care provider** (required) Date Signed

- All testing must have been completed between **7/1/2017–6/30/2018**.
- Primary care physician needs to complete all information with an * in front of it. Return signed form to participant.

* Does your patient have a history of coronary artery disease (MI, CABG, PTCA)? ☐ YES ☐ NO

* Does your patient have a history of diabetes? ☐ YES ☐ NO

* If no, does your patient have pre-diabetes? ☐ YES ☐ NO

* Does your patient exercise weekly? If so, how often? _____ days/week _____minutes/day

BIOMETRIC MEASURES	VALUE	TEST DATE (Month/Day/Year)
*Total Cholesterol		
*Triglyceride Level		
*Glucose (fasting)		
*HDL Cholesterol		
*LDL Cholesterol		
Hemoglobin A1c (if physician recommended)		
*Systolic Blood Pressure		
*Diastolic Blood Pressure		
*Height (in feet, inches)		
*Weight (in pounds)		
*Abdominal Circumference (in inches)		

Participant submit completed packet by 7/15/2018

Choose one:

- Scan and email to healthydirectionspcp@trihealth.com
- Send to the secure fax 513 852 3166
- Mail to Healthy Directions, 11129 Kenwood Road, Cincinnati, OH 45242

A + B + C + D + E =

Healthcare Premium Discount

Questions? Please contact healthydirectionspcp@trihealth.com or call **866 256 9007**.

Preventive Screening Confirmation Form

Employer Name: **City of Burnet**

Participant Name: _____ Date of Birth: _____

Preferred Phone: _____–_____–_____ Preferred Email: _____

A list is provided below of age and gender specific recommended preventive health screenings and the option to fill in another physician recommended preventive screening. **Your preventive screening can be completed between 7/1/2017 and 6/30/2018.** Please select one testing procedure from the list and use this form to document your preventive screening.

Any one of the following forms will be accepted for verification of these credits:

1. This form with the date of your screening and signature of a representative of the healthcare provider at the time of service.
2. An explanation of benefits (EOB) from your insurance company (must include type of service provided)
3. An itemized receipt from your healthcare provider's office or a healthcare provider note

This form MUST be signed off by the doctor who performed the service. *Example*: Your primary care physician cannot sign off on your dental visit!

Type of Service Provided	Date of Service
Annual PSA Test	___/___/___
Annual Gynecological Exam	___/___/___
Colonoscopy	___/___/___
Annual Mammogram	___/___/___
Annual Eye Exam	___/___/___
Skin Cancer Screening	___/___/___
Preventive Dental cleaning	___/___/___

I am authorizing that I am the healthcare provider who performed the service provided above:

_____

Signature of Healthcare Provider

_____

Name of Healthcare Provider

Participant: Submit completed packet by 7/15/2018.

Scan and email to:
healthydirectionspcp@trihealth.com

Send to our secure fax: 513-852-3166

Mail to: Healthy Directions
11129 Kenwood Road,
Cincinnati, Ohio 45242

U.S. Equal Employment Opportunity Commission

NOTICE REGARDING WELLNESS PROGRAM

Healthy Directions is a voluntary wellness program available to all plan members and their covered spouses. 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. You will be asked to complete a biometric screening, which will include a blood test that identifies biometric measures such as your cholesterol, glucose and triglyceride levels. You are not required to participate in the blood test or other medical examinations.

However, plan members who choose to participate in the wellness program will receive a discount on your insurance premium beginning October 1, 2018. Although you are not required to participate in the biometric screening, only employees who do so will receive the discount.

Confidentiality of Information

The wellness program and your employer listed below are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and your employer may use aggregate information it collects to design a program based on identified health risks in the workplace, Healthy Directions 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. No one except the third party wellness program administrator for the wellness program will receive your personally identifiable health information. 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, your employer 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 Sandra Graves at City of Burnet Human Resources at sgraves@cityofburnet.com.