2017 HERMANN SERVICES WELLNESS PROGRAM

Dear Hermann Services Employee:

We are sending this notice to inform you of the necessary steps that must be taken in order to for you to participate in the Wellness Program for 2017 and take advantage of reduced medical plan contributions for the 2016 plan year.

You and your enrolled spouse must complete the following actions by October 31st, 2017 in order to earn your contribution differential for the 2018 plan year.

- Get an annual physical that includes a biometric screening and submit the attached "Physician Screening Form"
- Complete your age and gender appropriate screenings as outlined on the attached page and submit the attached "Preventive Screening Submission Form"

Please return all forms to:

hermannwellness@usi.com via email OR (484) 652-5376 via fax

In the interest of your privacy and in compliance with HIPAA regulations, please DO NOT submit forms directly to Hermann Services Human Resources.

If you have any questions, please contact:

Jeanine Dunphy
x 116 or x124.

Sincerely,

Hermann Services Human Resources

Age and Gender Appropriate Screening Listing

All employees MUST complete the number of age and gender appropriate screenings in the matrix below:

	Under Age 40 (3 Screenings)	Age 40-49 (4 Screenings)	Age 50 and Over (5 Screenings)
Males	Annual Physical*	Annual Physical with Prostate Exam*	Annual Physical with Prostate Exam*
	Dental Exam	Dental Exam	Dental Exam
	Flu Immunization*	Flu Immunization*	Flu Immunization*
	Skin Cancer Screening	Skin Cancer Screening	Skin Cancer Screening
	Vision Screening**	Vision Screening**	Vision Screening**
		PSA Test*	PSA Test*
		Fecal "stool" Test*	Fecal "stool" Test*
			Colonoscopy*
	Under Age 40 (3 Screenings)	**Age 40-49 (5 Screenings)**	**Age 50 and Over (5 Screenings)**
Female	Annual Physical*	Annual Physical*	Annual Physical *
	Dental Exam	Dental Exam	Dental Exam
	Flu Immunization*	Flu Immunization*	Flu Immunization*
	Skin Cancer Screening	Skin Cancer Screening	Skin Cancer Screening
	Vision Screening**	Vision Screening**	Vision Screening**
	Well -Woman Exam with pap Smear*	Mammogram*	Mammogram*
		Fecal "stool" Test*	Fecal "stool" Test*
		Well -Woman Exam with pap Smear*	Colonoscopy*
			Well -Woman Exam with pap Smear*

* Covered at 100% on both Hermann Services medical plans once every 12 months at a participating provider

** Covered at 100% on both Hermann Services medical plans once every 24 months at a participating provider

Hermann Services Preventive Screening Submission Form

Bring this checklist to you provider and him or her indicate which preventive care services you have completed.

Participant Name: ____

Email Address (for confirmation of receipt): ____

Please submit this form to: hermannwellness@usi.com OR (484) 652-5376 (fax)

In the interest of your privacy and in compliance with HIPAA regulations, please DO NOT submit forms directly to Hermann Services Human Resources.

To the provider:

As part of the Hermann Services wellness program, employees are encouraged to get their annual physical and receive all of their age and gender appropriate screenings. Please indicate which preventive care services and the dates of these services your patient has received.

Service ***Date***

Both men and Women:

- ☐ **Annual Physical with Biometric Screenings** __________
- ☐ **Dental Exam** __________
- ☐ **Flu Immunization** __________
- ☐ **Skin Cancer Screening** __________
- ☐ **Vision Screening** __________
- ☐ **Fecal "Stool" Test (Over age 40)** __________
- ☐ **Colonoscopy (Over age 50)** __________
- ☐ **Osteoporosis Screening (Over age 50)** __________

Women Only

- ☐ **Well Woman Exam** __________
- ☐ **Pap Smear** __________
- ☐ **Mammogram (Over age 40)** __________
- ☐ **Osteoporosis Screening (Over age 50)** __________

Men Only

- ☐ **Prostate Exam (Over age 40)** __________
- ☐ **PSA Test (Over age 40)** __________

Provider Signature:

____

Please stamp with provider office stamp here:

Hermann Services, Inc.

Physician Screening Form

Email or Fax completed form to: Hermann.Wellness@usi.biz or (484) 652-5376

DUE DATE: October 31, 2017

In the interest of your privacy and in compliance with HIPAA regulations, please DO NOT submit forms directly to Hermann Services Human Resources.

PARTICIPANT: Please ask your provider to complete this form with your blood/screening test results to satisfy the biometric component of your wellness program. These results are confidential and will not be disclosed except in accordance with HIPAA laws.

PARTICIPANT NAME: ______________________________ SELECT ONE: Employee Spouse/DP

PARTICIPANT DATE OF BIRTH: ______________________ PARTICIPANT PHONE #: ______________________________

****IMPORTANT NOTES*****

- You may submit test results completed by your provider on or after **November 1, 2016.**
- You or your physician may email or fax this form to USI.
- These biometric results are due to USI no later than **October 31, 2017.**

PROVIDER: This health management program is not intended to treat, diagnose or replace physician involvement, but rather to create and promote an atmosphere of healthy living and learning through the implementation of wellness initiatives. For more information, please call your Human Resources Team at extension 116 & 124.

PROVIDER NAME / CLINIC:_________________________________ PHONE #: (________) __________________________

ADDRESS: ____CITY: ____________________________STATE: __________

PROVIDER / CLINIC SIGNATURE: ____

LICENSE TYPE/NUMBER: __________________________________

LAB & SCREENING TESTS DATE: _____/_____/_____

ALL VALUES IN CHART MUST BE COMPLETED TO RECEIVE CREDIT

TEST PARAMETER	VALUE	UNITS
Total Cholesterol		**mg/dL**
HDL Cholesterol		**mg/dL**
LDL Cholesterol		**mg/dL**
Triglycerides		**mg/dL**
Glucose		**mg/dL**
Systolic Blood Pressure (rest)		**mmHg**
Diastolic Blood Pressure (rest)		**mmHg**
Height		**ft/in**
Weight		**lbs**
Waist Circumference		**in**
FASTING: YES / NO		

USI UNDERSTAND. SERVICE. INNOVATE.