

## *AWF Conference Board of Pension & Health Benefits*

### **Health and Wellness Initiative Program**

At the Alabama West Florida Conference United Methodist Conference, we take pride in our clergy and staff members. We want you to feel your best, so we believe that one of life's most important goals should be good health. By taking steps toward a healthy lifestyle, you can increase your energy, decrease your chance of developing preventable illnesses and best of all, feel better. With that being said, the conference's health insurance plan is self-insured – our claims are our expenses. Participants' health claims are increasing. The purpose of the 2017 wellness initiative is to identify health issues for participants so they can live longer, healthier and more productive lives.

Starting January 1, 2017, AWFUMC will continue our wellness initiative for clergy participants enrolled in the conference's active health plan. Participants will need to complete 2 requirements; an online Health Quotient and a biometric screening (blood screening).

- The Health Quotient (HQ) is an online health assessment provided by Blue Cross Blue Shield of Alabama's *myBlueWellness*' website. The HQ will help identify areas of your life that may be negatively impacting your health. Complete the HQ starting 1/1/2017.
- Biometric screening (non-fasting) is a simple test consisting of height, weight, blood pressure, and finger stick. The biometric screening will help you identify, understand, and reduce your risks.

There will be several opportunities for completion of the HQ and biometric screening.

- Annual Conference, June 4-5, 2017. Screening will be held from 8:00 am until 2:00 pm on Monday, June 4 and Tuesday, June 5, 2017. It is a non-fasting screening.
- Bishop Day's Apart (HQ only) by advance appointment. Call the Conference Office 888-873-3127
- The biometric screening can be completed at your **Primary doctor office**.  
*(Download the Quest Bio-Screening Form via from the Conference website and take with you to the doctor's office. Either you or the doctor will need to be fax to Quest Diagnostics at (248)864-4409)*

**Participants must complete the HQ and the biometric screening by August 31, 2017.**

Participants who have not completed both requirements by August 31, 2017 will be charged a personal \$50 monthly health surcharge in addition to the regular health premium equivalent charged to the church. This annual surcharge will remain in effect for all of 2018.

If you have questions or concerns, please contact the Chairman for the Conference Pension and Health Benefits Committee, Robert McKibben ([revbmck@bellsouth.net](mailto:revbmck@bellsouth.net)) or the Conference Benefits Officer, Frank Dunnewind ([frank@awfumc.org](mailto:frank@awfumc.org)).

## ***AWF Conference Board of Pension & Health Benefits***

### **Health and Wellness Initiative Program Q&A**

**1. *What is the Wellness Initiative Program?***

A program to identify health issues for participants so they can live longer, healthier and more productive lives

**2. *When did it start and who must participate?***

January 2017

All active clergy and retired clergy under age 65 on the Conference active health plan insurance plan

**3. *Why should I participate in this screening?***

You will be able to:

- Find out what your 'health indicators' are (blood pressure, cholesterol levels, weight)
- Identify potential health risks
- Receive an informational brochure with your personal results
- Avoid paying a \$50 per month personal surcharge for health insurance during 2018

**4. *Will the test cost anything?***

- No, not for screening at Annual Conference; this test is part of the Conference Wellness Initiative Program and is FREE to eligible participants.
- If you go to your primary doctor, there will be a co-pay associated with the visit and cost associated with additional test your doctor may request.

**5. *Who is eligible to participate in the screenings?***

Eligible participants include employees and their spouses/dependents, Retirees and spouse/dependents enrolled on the Conference health insurance plan

**6. *Is fasting required?*** No

**7. *How to do I enroll?*** Register at [\*myBlueWellness\*](#). Complete the HQ.

**8. *What is the deadline?*** August 31, 2017

**9. *Why do I have to pay a surcharge?***

Clergy must complete the HQ and the biometric screening by August 31, 2017. Participants who have not completed both requirements will be charged a personal \$50 monthly health surcharge in addition to the regular premium equivalent because persons with untreated health issues create higher claims for the Annual Conference.

**10. *How long will I have to pay the surcharge if I don't complete the requirements?***

This charge will remain in effect for a 12 month period beginning January 1, 2018. Completion of the requirements after September 1, 2017 will not reduce the 12 month surcharge.

**11. *Will there be a wait time for the screening?***

At Annual Conference, there may be some wait time depending on the level of participation.

**12. *What about privacy and protecting participants' personal health information?***

The health screening layout is designed for efficient flow, from the registration table to the screening stations and counseling areas. Any Personal Health Information (PHI) gathered during the screening is protected by federal and state privacy laws including the Health Insurance Portability and Accountability Act (HIPAA).

**13. *Will this screening impact my premium equivalent?***

- Your individual premium equivalent will not be impacted. However, failure to complete the screening will result in a surcharge to you.
- However, yes, if your areas for improving health are identified and you work on improving your health so that claims are reduced, projected claims may reduce premium equivalent.

**Alabama West Florida United Methodist Conference  
Health Care Provider Biometric Screening Form**

**INSTRUCTIONS:**

- PARTICIPANT - complete section 1
- HEALTH CARE PROVIDER - complete section 2

Please fax completed form to Quest Diagnostics Health & Wellness Services at **(248) 864-4409**

**SECTION 1 - PARTICIPANT INFORMATION - Print clearly. If the form is illegible it will not be processed.**

Participant's Date of Birth (MM/DD/YYYY)		Gender	Unique ID#
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>
Participant's First Name		MI	Participant's Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address			Unit/Apt
<input type="text"/>			<input type="text"/>
City		State	Zip Code
<input type="text"/>		<input type="text"/>	<input type="text"/>
Email Address			
<input type="text"/>			
Phone Number		Are you:	
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent

**Please read the following disclosure statement.** I understand that my health screening data will be released to health plans associated with my company for the purpose of follow-up health education and disease management counseling (if eligible). My individually identifiable health information will not be shared with my Employer; however my Employer may be advised of the fact of my participation in this health screening for purposes of qualification for incentives offered by my Employer. In addition, if my Employer offers incentives related to "pass/fail" test results, my "pass/fail" test results may be disclosed to my Employer for those incentive purposes. My health screening test results may be disclosed to vendors engaged by my Employer or Employer-sponsored group health plan for purposes of determining my eligibility for an incentive related to this health screening, for health management and/or disease management services including data aggregation for program improvement purposes, and/or for purposes of population of my Personal Health Record available online and/or my Health Risk Assessment (HRA). The importance of safeguarding individually identifiable health information is recognized and all organizations involved in this Biometric Health Screening are obligated to take reasonable steps to protect such information from unauthorized access or use.

Participant's Signature: \_\_\_\_\_ Date:      
(Month) (Day) (Year)

**PATIENTS: Biometric Screening must be completed by 8/31/17** to receive completion credit or incentive (if applicable). This form must also be completed in its entirety and legible in order to be deemed complete.

**SECTION 2 - BODY MEASUREMENTS / BIOMETRICS RESULTS - For physician or office staff use only below this line.**

FOR HEALTH CARE PROVIDER: *Alabama West Florida United Methodist Conference* is offering a voluntary wellness program to encourage participants to understand their health risk.

<b>Blood Panel</b> Total Cholesterol: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> HDL: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Triglycerides: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> LDL: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> TC/HDL Ratio: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Glucose: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		<b>Fasting Status (Check one)</b> <input type="checkbox"/> Fasting <input type="checkbox"/> Non-Fasting	<b>Blood Pressure</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Systolic <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Diastolic
<b>Body Composition</b> Height <input type="text"/> ft <input type="text"/> in <input type="text"/> <input type="text"/> BMI <input type="text"/> <input type="text"/> Waist <input type="text"/> <input type="text"/> Weight <input type="text"/> <input type="text"/> <input type="text"/> lbs <input type="text"/> <input type="text"/> Body Fat% <input type="text"/> <input type="text"/> Hip <input type="text"/> <input type="text"/>		<b>Pulse</b> <input type="text"/> <input type="text"/> <input type="text"/>	<b>Tobacco Use</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>For Females Only:</b> Currently Pregnant or Pregnant within the last 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No			

I certify the listed biometric values are correct

Facility Name: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Date of Service/Test: \_\_\_\_\_  
 Health Care Provider's Name: \_\_\_\_\_  
 Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please fax completed form to Quest Diagnostics Health & Wellness Services**

**at (248) 864-4409 by Deadline 8/31/17**

Date Faxed: \_\_\_\_\_

**NOTICE: Any form submitted incomplete, inaccurate or not legible will be deemed invalid**