Notice Regarding Wellness Program

Your Group Health Plan's Wellness Program is a voluntary wellness program available to all employees, and spouses if applicable, who are enrolled in the company's Group Health 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 may be asked to see a physician for a preventive health visit and have a form completed that includes confirmation you have received certain tests and/or screenings. The form may collect information on whether certain screenings have been done and whether or not you meet certain standards, such as body mass index, blood pressure, LDL cholesterol, glucose, and nicotine use. The form may also ask for information regarding whether your provider discussed mental health awareness, nicotine use, and whether or not you have had certain preventive screenings recommended based upon your age and gender. You are not required to have the form completed, or to participate in the medical exam, blood tests, or screenings in order to participate in the Group Health Plan. For the specific requirements in place for your wellness program, visit the Incentives and Rewards tile on the ActiveCare home page.

Incentives and Reasonable Accommodation

Employees, and their spouses if applicable, who are enrolled in the Group Health Plan who do choose to participate in the Wellness Program and who timely complete the requirements will be able to earn an incentive. Incentives are determined annually and can be viewed on the Incentives and Rewards tile on the ActiveCare home page. If a certification of an annual wellness exam is required, it must be fully completed and returned by the specified deadline. Although you are not required to complete all wellness incentive activities, only employees, and spouses if applicable, who do so will receive an incentive.

The Group Health Plan is committed to helping you work toward and achieve your best health. Rewards for participating in the Wellness Program are available to all employees, and spouses if applicable, who participate in the group health plan. If you are unable to participate in the preventive health visit, any of the medical tests, or screenings because of a medical reason, you may be entitled to a reasonable accommodation or an alternative standard. We will work with you (and, if you wish, with your doctor) to find an alternative that is right for you in light of your health status. You may request a reasonable accommodation or an alternative standard by contacting LShelby@nlr.ar.gov.

You are encouraged to discuss the results of any medical exam with your own doctor. Aggregate information regarding the Wellness Program may be provided to your employer

and your employer's vendors who assist in administering the wellness program (if applicable), to enable your employer to choose health related programs that would most benefit its workforce and to administer the wellness program.

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 your employer may use aggregate information collected to design a program based on identified health risks in the workplace, the Wellness Program 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, to administer 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 individuals who will receive your personally identifiable health information are those employed by third party vendors who administer the Wellness Program, if applicable, and Stephens Insurance, LLC, in order to assist your employer in the program oversight, evaluation and planning.

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 were to occur involving information you provide in connection with the Wellness Program, you will be notified as soon as is administratively feasible.

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 your Human Resources Department.

_____ _____

Employee Signature Date

WELLNESS INCENTIVE FORM

Return the completed form lshelby@nlr.ar.gov or mail to 700 W 29th ST, North Little Rock, AR 72114

☐ Dental Exam

☐ Ovarian Screen ☐ Breast Cancer ☐ Skin Screen ☐ Lung Screen ☐ Pap Smear ☐ Colon Screen ☐ Vaccines ☐ Eye Exam ☐ Hearing Screen ☐ Biometric Screen

EMPLOYEE INFORMATION The employee is the person employed by who is the primary enrollee in the health plan.

Last Name | First Name | Middle Initial | Date of Birth

PATIENT INFORMATION AND AUTHORIZATION The patient is the person receiving the exam. It may be the employee named above or the employee's spouse.

Last Name | First Name | Middle Initial | Date of Birth

Last 4 Digits of SSN | Gender (Select) | Relationship to Employee (Self or Spouse)

Email Address

Patient Authorization: I have received the Notice regarding the confidentiality of this information and I understand that any information collected as part of the annual wellness program as applicable, including information collected such as medical preventive exams, health risk assessment, and biometric screening results, will be treated as confidential. Individual health information will not be shared with my employer, but my employer may receive aggregate information to assist in determining potentially beneficial programs to be offered in the future and information needed to administer the incentive payment. I also understand that this authorization is valid for a period of one year unless otherwise withdrawn. Please contact your employer for a copy of its Notice of Privacy Practices.

I understand that below information will be used in the following ways:

- By my provider as a means of informing me of my health risk and possible actions I can take to help me live a healthy life;
- To evaluate the impact of the wellness program;
- To provide my employer aggregate information as part of a group summary report and to administer the wellness program.

If I falsify any information, I understand I may be ineligible from any and all future Wellness Programs.

Patient Signature | Date

PROVIDER CERTIFICATION Please enter the date of the exam and complete each section based on the patient's current health status and care plans.

☐ If the patient should be exempt from one or more of these tests, please check this box and provide an explanation:

Provider Name | Provider NPI

Provider Phone # | Exam Date

I certify that this patient received a wellness exam as indicated by the tests shown on this form or is exempt from one or more test items as explained above.

Provider Signature | Date

WELLNESS/ EXAMINCENTIVE FORM **Patient:** _____

At today's visit did the patient receive any of the following screenings? ☐Yes ☐ No

☐ Lung Cancer ☐ Skin Cancer ☐ Ovarian Cancer ☐ Prostate Cancer ☐ Breast Cancer ☐Hearing Screening
☐Colon Screening ☐Eye Exam ☐Dental Exam

At today's visit did the patient receive any of the listed VACCINES ? ☐ Yes ☐ No

☐Annual Flu Vaccine ☐Shingles Vaccine ☐Pneumonia Vaccine ☐COVID Vaccine ☐COVID Booster

If the patient is 40 years or older, did you have a discussion on whether a mammogram is appropriate? ☐Yes ☐ No

If applicable, is this patient up to date on mammogram screenings?

If the patient is 21 years or older, did they have an Pap Smear at todays visit? ☐Yes ☐ No

If the patient is 40 years or older, did they get an mammogram? ☐ Yes ☐ No

If the patient is a Male , did they receive an Prostate exam on today? ☐ Yes ☐ No

If the patient is 21 years or older and has a cervix, are they up to date on cervical cancer screenings? ☐ Yes ☐ No

If the patient is 45 years or older, are they up to date on colon cancer screenings? ☐ Yes ☐ No

Screening type: ☐ Colonoscopy ☐ Cologuard ☐ FIT ☐ Other

Is the patient's systolic blood pressure within normal range? ☐ Yes ☐ No

Is the patient's diastolic blood pressure within the normal range? ☐ Yes ☐ No

Height: Feet_____ inches _____**Weight:** _____ lbs **BMI:**_____

Does this person have a diabetes-related diagnosis? ☐ No Diabetes Diagnosis ☐ Pre-Diabetes ☐ Type 1 Diabetes ☐ Type 2 Diabetes

Is the patient's cholesterol within normal range? ☐ Yes ☐ No

Does this patient use tobacco? ☐ Yes ☐No

If tobacco products are being used, is the patient participating in any of the following tobacco cessation programs?

☐ Nicotine Replacement ☐ Medication Initiation
☐ Behavioral Counseling ☐ None

Has the patient been screened for depression or anxiety? ☐ Yes ☐ No

What is the patient's annual health goal?

☐ Diet ☐ Stress Management/Burnout
☐ Depression/Anxiety ☐ Self-Care
☐ Other:_____ ☐ None