Program Instructions

Three simple activities, three opportunities to earn rewards!

VISIT YOUR PROVIDER

A frank, yearly discussion with your health care provider to create an individualized care plan is an important step in staying healthy.

COMPLETE A HEALTH SURVEY

We'd like to get to know you better. Completing our short health survey helps us make tailored suggestions on how to keep you healthy.

OBTAIN LAB TESTS

Assessing your health starts with basic lab tests. Have your provider order lab tests and discuss the results with them.

$75 reward + **$75 reward** + **$100 reward** = **$250 in rewards!**

Four easy steps to earn and redeem your rewards!

1

Choose an activity, in any order you wish. Each activity is color-coded, and consists of an activity form, plus a reward request form.

2

Mail the completed, color-coded activity and reward forms in the enclosed envelopes to:
Lasso Healthcare
2605 Interstate Drive
Suite 300
Harrisburg, PA 17110.

3

We'll process your forms. Reward requests will be processed within five business days after receipt. Please allow up to 21 business days to receive a physical card via mail.

4

Repeat this process for all three activities to earn $250 in rewards!

Questions? Contact us at 800-918-3859 (TTY: 711). We are available Monday - Friday, 8 a.m. to 4:30 p.m. Eastern time, or email us at wellness@lassohealthcare.com.

Participation Rules and Tracking

Participation Rules

1. The Activity Forms (i.e. one form each for the Health Survey, the Annual Wellness Visit, and Lab Work) and the accompanying Reward Request Forms must be completed in the plan year that they were received.
2. Rewards will be processed for the activity forms from the prior year's incentive that are postmarked before the end of the plan year and received up to 30 days into the new calendar year.
3. Each Activity Form must be completed in full and in accordance with form instructions.
4. Incomplete or illegible forms may delay processing of a reward. An outreach from us may be required to obtain the information required to complete the form for reward processing.

Activity and Reward Tracking

1. **Health Survey**

   Date Activity and Reward Request Forms Submitted: _____ / _____ / _____
   Month *Day* *Year*

   Date Physical or eCard Reward Received: _____ / _____ / _____
   Month *Day* *Year*

2. **Annual Wellness Visit**

   Date Activity and Reward Request Forms Submitted: _____ / _____ / _____
   Month *Day* *Year*

   Date Physical or eCard Reward Received: _____ / _____ / _____
   Month *Day* *Year*

3. **Lab Work**

   Date Activity and Reward Request Forms Submitted: _____ / _____ / _____
   Month *Day* *Year*

   Date Physical or eCard Reward Received: _____ / _____ / _____
   Month *Day* *Year*

Activity Form: Health Survey

Congratulations for taking an active role in your health! Taking the time to complete a health survey is a great way to understand your current health status - **and get rewarded for it!** Please complete all survey sections and submit your survey by December 31.

Section 1: Your Identity Basics

Lasso Healthcare ID#: _____ DOB: ___/___/___
Month Day Year

First Name: _____ Gender: ◯ Male ◯ Female

Last Name: _____ Height: ____ ft. ____ in. Weight: _____ lbs.

Name of Primary Medical Provider: _____
(First and Last Name)

Name(s) of Specialist(s): _____
(First and Last Names)

_____

_____

Section 2: Your Hospitalization History

2.1 Have you been to the emergency room within the last year? ◯ Yes ◯ No (if No, skip to 2.2)

If Yes, what was the date of your most recent visit? ___/___/___
Month Day Year

If Yes, for what? ◯ Accident (e.g., car accident, fall, etc.) ◯ Pain not caused by accident ◯ Illness ◯ Other

2.2 Have you been admitted to the hospital overnight? ◯ Yes ◯ No (if No, skip to Section 3)

If Yes, for what? _____

Section 3: Your Medications and Supplements

3.1 Are you currently taking any prescription medications? ◯ Yes ◯ No

If so, how many? _____

3.2 Are you taking any non-prescription medications or supplements? ◯ Yes ◯ No

If so, how many? _____

Section 4: Your Chronic Conditions

Diabetes

4.1 Have you ever been diagnosed with diabetes or pre-diabetes? ◯ Yes ◯ No (if No, skip to 4.2)

Do you currently have diabetes or pre-diabetes? ◯ Yes ◯ No (if No, skip to 4.2)

Were you diagnosed with Type 1, Type 2, or pre-diabetes? ◯ Type 1 ◯ Type 2 ◯ Pre-diabetes ◯ I don't know

Have you had complications? ◯ Yes ◯ No

If Yes, please describe the complications: _____

Do you self-manage (e.g., glucose tests, exercise, diet, etc.)? ◯ Yes ◯ No

How often do you see your medical provider? ◯ Monthly ◯ Quarterly ◯ Annually ◯ Other: _____

Did you have a lab test during the past year that tested your A1C levels? ◯ Yes ◯ No ◯ I'm not sure

Have you had an eye exam during the past year? ◯ Yes ◯ No ◯ I'm not sure

Have you had a kidney function test during the past year? ◯ Yes ◯ No ◯ I'm not sure

High Blood Pressure

4.2 Have you ever been diagnosed with high blood pressure? ◯ Yes ◯ No (if No, skip to 4.3)

Do you currently have high blood pressure? ◯ Yes ◯ No (if No, skip to 4.3)

Did you receive treatment or medication for your blood pressure in the past year? ◯ Yes ◯ No

What was your blood pressure when last checked? _____ / _____ ◯ I'm not sure
(e.g. 120 / 80)

Heart

4.3 Have you been diagnosed with a heart condition, such as: Irregular Heartbeat (i.e. atrial fibrillation or AFIB), Angina (e.g. chest pain with exercise), Heart Attack, or Heart Failure (HF)? ◯ Yes ◯ No (if No, skip to 4.4)

If Yes, please list condition: _____

Are you under the care of a medical provider for your condition? ◯ Yes ◯ No

Section 4: Your Chronic Conditions, continued...

Lung

4.4 Have you ever been diagnosed with a chronic lung condition (respiratory) such as Chronic Obstructive Pulmonary Disease (COPD) or asthma? ◯ Yes ◯ No

If Yes, please list condition: _____

Have you had any serious lung conditions, such as pneumonia? ◯ Yes ◯ No (if No, skip to 4.5)

Are you under the care of a medical provider for your condition? ◯ Yes ◯ No

Kidneys

4.5 Have you ever been diagnosed with a serious kidney condition, such as kidney failure (nephropathy)? ◯ Yes ◯ No (if No, skip to 4.6)

If Yes, please list condition: _____

Are you on dialysis? ◯ Yes ◯ No

Are you under the care of a medical provider for your condition? ◯ Yes ◯ No

Liver

4.6 Have you ever been diagnosed with a liver condition, such as hepatitis or cirrhosis? ◯ Yes ◯ No (if No, skip to 4.7)

If Yes, please list condition: _____

Are you under the care of a medical provider for your condition? ◯ Yes ◯ No

Cancer

4.7 Have you ever been diagnosed with cancer? ◯ Yes ◯ No (if No, skip to 4.8)

If Yes, please list type of cancer: _____

Are you under the care of a medical provider for your condition? ◯ Yes ◯ No

Other Chronic Conditions

4.8 Have you ever been diagnosed with any other chronic conditions, such as arthritis, Lupus, Chrohn's Disease, osteoporosis, or any other chronic conditions? ◯ Yes ◯ No (if No, skip to 4.9)

If Yes, please list condition: _____

Are you under the care of a medical provider for your condition? ◯ Yes ◯ No

Section 4: Your Chronic Conditions, continued...

Mental Health

4.9 Have you ever been diagnosed with a mental health disorder, such as bipolar disorder, schizophrenia, or depression? ◯ Yes ◯ No (if No, skip to Section 5)

If Yes, please list condition: _____

Are you under the care of a medical provider for your condition? ◯ Yes ◯ No

Section 5: Lifestyle Profile

5.1 How many alcoholic beverages do you consume, on average, per week? (A typical drink is 12 oz. of beer, 5 oz. of wine, or 1.5 oz. of liquor.) ◯ 0 ◯ 1-3 ◯ 4-7 ◯ >7

5.2 Have you taken any opioids or narcotics, prescribed or unprescribed, in the last year? ◯ Yes ◯ No (if No, skip to 5.3)

Who prescribed the opioid/narcotic? ◯ PCP/Specialist ◯ Urgent Care/ER ◯ Unprescribed

Are you taking it regularly for chronic pain? ◯ Yes ◯ No

5.3 Do you use tobacco products? ◯ Yes ◯ No (if No, skip to 5.4)

Are you interested in quitting? ◯ Yes ◯ No

5.4 Do you exercise regularly? ◯ Yes ◯ No (if No, skip to Section 6)

How often? ◯ 1-2 times/week ◯ 3-5 times/week ◯ 5+ times/week

What types of exercise? ◯ Swimming ◯ Walking/Hiking ◯ Jogging/Running ◯ Biking ◯ Yoga/Pilates ◯ Strength Training/Weights ◯ Aerobics ◯ Other: _____

Section 6: Preventive Activities

6.1 Do you have an annual or routine physical or wellness visit with your medical provider? ◯ Always ◯ Most years ◯ Sometimes ◯ Rarely ◯ Never

6.2 Do you regularly get your annual flu vaccination? ◯ Yes ◯ No

6.3 Have you been vaccinated for shingles? ◯ Yes ◯ No

6.4 Have you been vaccinated for pneumonia? ◯ Yes ◯ No

Section 6: Preventive Activities, continued...

6.5 Have you ever had a colonoscopy or colorectal screening? ◯ Yes ◯ No (if No, skip to 6.6)

If Yes, how long ago was your most recent screening? ◯ <1 Year ◯ 1-2 Years ◯ 3-5 Years ◯ >5 Years

6.6 Have you had a bone density screening (i.e. a bone mass measurement)? ◯ Yes ◯ No (if No, skip to 6.7)

If Yes, how long ago was your most recent screening? ◯ <1 Year ◯ 1-2 Years ◯ 3-5 Years ◯ >5 Years

6.7 Have you had a problem with falling, walking, or balancing over the past year? ◯ Yes ◯ No

6.8 Have you ever had a mammogram? ◯ Yes ◯ No ◯ Not Applicable (If No or Not Applicable, skip to 6.9)

If Yes, how long ago was your most recent screening? ◯ <1 Year ◯ 1-2 Years ◯ 3-5 Years ◯ >5 Years

6.9 Have you ever had a prostate cancer screening? ◯ Yes ◯ No ◯ Not Applicable (If No or Not Applicable, skip to Section 7)

If Yes, how long ago was your most recent screening? ◯ <1 Year ◯ 1-2 Years ◯ 3-5 Years ◯ >5 Years

Section 7: Coronavirus (COVID-19)

7.1 Have you ever been diagnosed with COVID-19? ◯ Yes ◯ No

Do you have any ongoing symptoms? If Yes, please list: _____

Reward Request: Health Survey

Congratulations on completing the health survey!

Please fill out this form and return with your completed health survey in the enclosed envelope.

First Name: _____ Member ID: _____

Last Name: _____ Phone: _____

STEP 1: Select one $75 reward. Place an X next to the $75 reward you wish to receive. Choose your reward:

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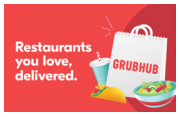
4 

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Please note Visa® Reward cards are only distributed via mail as physical cards; a Visa reward cannot be requested/received via email.

The physical Visa Reward card can be used for both online and in-store purchases.

STEP 2: Select your delivery. Place an X next to the email or mail delivery option below. Provide the address to send your e-code or physical card.

☐ E-code via email address*: Fastest delivery!

Use this email: _____

*You agree to receive email from Lasso Healthcare.

☐ Physical card via mailing address:

Use this address: _____

_____

Program incentives, reward brands and amounts are subject to change. Please allow up to three weeks from time of reward request receipt for mail delivery of your physical gift card reward. For faster delivery, choose e-code as your delivery method. Rewards cannot be replaced if lost or stolen. Rewards are non-redeemable for cash.

Activity Form: Lab Work

A simple blood test can earn you a reward! Complete Section 1 of this form, then ask either your medical provider (e.g. your physician) or lab provider (e.g. the lab manager, lab technician, phlebotomist, etc.) to complete and sign Section 2. Please return the completed form by December 31.

Section 1: To be completed by you

Member First Name _____ Member Last Name _____

Member ID # _____

Provider Name _____
(First and Last Name)

Section 2: To be completed by your medical or lab provider

The purpose of the patient presenting this form to you is to help them follow preventive care guidelines and to qualify them for a member health incentive from Lasso Healthcare. If the patient completed lab work within the last three months, or the most recent lab work is still considered clinically valid in your opinion, new lab work does not have to be drawn.

Date of Last Lab Work: ____ / ____ / ____
Month Day Year

Was the prescribed lab work completed per medical provider's order? ◯ Yes ◯ No

Are the results still clinically valid? ◯ Yes ◯ No

Provider Name _____ Today's Date ____ / ____ / ____
Month Day Year

Provider Signature _____ NPI _____
(MD, DO, NP, PA)

Reward Request: Lab Work

Please fill out this form and return with your completed lab work form in the enclosed envelope.

First Name: _____ Member ID: _____

Last Name: _____ Phone: _____

STEP 1: Select one $75 reward. Place an X next to the $75 reward you wish to receive. Choose your reward:

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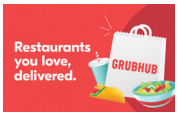
4 

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Please note Visa® Reward cards are only distributed via mail as physical cards; a Visa reward cannot be requested/received via email.

The physical Visa Reward card can be used for both online and in-store purchases.

STEP 2: Select your delivery. Place an X next to the email or mail delivery option below. Provide the address to send your e-code or physical card.

☐ E-code via email address*: Fastest delivery!

Use this email: _____

*You agree to receive email from Lasso Healthcare.

☐ Physical card via mailing address:

Use this address: _____

_____

Program incentives, reward brands and amounts are subject to change. Please allow up to three weeks from time of reward request receipt for mail delivery of your physical gift card reward. For faster delivery, choose e-code as your delivery method. Rewards cannot be replaced if lost or stolen. Rewards are non-redeemable for cash.

Activity Form: Annual Wellness Visit

Complete Section 1 of this form, then ask your medical provider to complete and sign Section 2. Please return the completed form by December 31.

If your visit was conducted in a telehealth setting using a device such as your phone, tablet, laptop, or PC, you must provide both the name of the medical provider who treated you and their NPI # for your reward to be processed. The medical provider's signature is not required.

Section 1: To be completed by you

Member First Name _____ Member Last Name _____

Member ID # _____ Date of Service ____ / ____ / ____
Month Day Year

Type of Visit
(Select one)
◯ Welcome to Medicare Visit ◯ Medicare Annual Wellness Visit ◯ Routine Physical

How was your visit conducted?
(Select one)
◯ In-person (office) ◯ Virtual/Telehealth*

**For virtual/telehealth visits only:*

Provider Name _____ NPI _____
(MD, DO, NP, PA)

Section 2: To be completed by your medical provider (for in-person visits)

Important information for your healthcare provider:

The purpose of the patient presenting this form to you is to help them follow preventive care guidelines and to qualify them for a member health incentive from Lasso Healthcare. Today's visit should form the foundation of a personal care plan for the patient to follow. If you provided the patient an Annual Wellness Visit or Routine Physical within the last six months, and in your opinion the visit is still clinically valid, another wellness visit is not required.

Provider Name _____ Today's Date ____ / ____ / ____
Month Day Year

Provider Signature _____ NPI _____
(MD, DO, NP, PA)

Reward Request: Annual Wellness Visit

Congratulations on completing your annual wellness visit!

Please fill out this form and return with your completed annual wellness visit form in the enclosed envelope.

First Name: _____ Member ID: _____

Last Name: _____ Phone: _____

STEP 1: Select one $100 reward. Place an X next to the $100 reward you wish to receive. Choose your reward:

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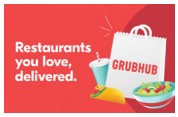
4 

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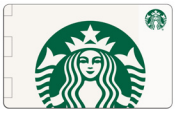
7 

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☐ E-code via email address*: Fastest delivery!

Use this email: _____

*You agree to receive email from Lasso Healthcare.

☐ Physical card via mailing address:

Use this address: _____

_____

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IMPORTANT INFORMATION

[1]Restrictions apply, see amazon.com/gc-legal.

[2]Cracker Barrel Old Country Store, Inc. is not affiliated with Lasso Healthcare, and is not a sponsor, co-sponsor or endorser of this promotion, or any products or services provided by Lasso Healthcare or any other third parties pursuant to such promotion. Please see back of gift card for terms and conditions of use. Cracker Barrel Old Country Store, Inc. and Cracker Barrel Old Country Store® locations are not liable for any alleged or actual claims related to this promotion or the products and/or services provided by Lasso Healthcare or any third party. ©2017 CBOCS Properties, Inc. "Cracker Barrel Old Country Store" name and logo are registered trademarks of CBOCS Properties, Inc.

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[10]Use of this card constitutes acceptance of the following terms. Cards cannot be redeemed until activated. Purchases with the card will be deducted from the balance until it reaches $0.00. The card is redeemable for merchandise only (excluding gift cards) at T.J. Maxx, Marshalls, HomeGoods, Homesense, and Sierra stores (in the U.S. and Puerto Rico) and online at tjmaxx.com, marshalls.com, and sierra.com and cannot be redeemed for cash except where required by applicable law. If lost or stolen, it will not be replaced. This card has no expiration date and incurs no dormancy fees. Any term is void where prohibited by law. This card is issued by and represents an obligation of TJX Incentive Sales, Inc., a Virginia corporation.

[11]Lasso Healthcare is not affiliated with Walmart Stores, Inc., or any of its affiliates. The services, products or activities of Lasso Healthcare are neither endorsed nor sponsored by Walmart Stores, Inc., or any of its affiliates. See www.walmart.com/giftcardtermsandconditions for complete gift card terms and conditions.

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Discrimination is Against the Law

Lasso Healthcare (MSA) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Lasso Healthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Lasso Healthcare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.
If you believe that Lasso Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Lasso Healthcare
P.O. Box 261115
Plano, TX 75026
Fax 800-419-6475

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Ave, SW, Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Attention: Language assistance services, free of charge, are available to you. Call 1-866-766-2583 (TTY: 711).

Español (Spanish):

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-766-2583 (TTY: 711).

Kreyòl Ayisyen (French Creole)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-766-2583 (TTY: 711)

Tiếng Việt (Vietnamese):

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-766-2583 (TTY: 711).

Polski (Polish):

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-766-2583 (TTY: 711).

Português (Portuguese)

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-766-2583 (TTY: 711).

繁體中文 (Chinese):

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-766-2583 (TTY:711)。

Ilokano (Ilocano):

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-866-766-2583 (TTY: 711).

Tagalog (Tagalog – Filipino):

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-766-2583 (TTY: 711).

한국어 (Korean):

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-766-2583 (TTY: 711) 번으로 전화해 주십시오.

Français (French):

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-766-2583 (ATS: 711).

Hmoob (Hmong):

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1- 866-766-2583 (TTY: 711).

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-766-2583 (رقم هاتف الصم والبكم: 711).

日本語 (Japanese):

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-766-2583（TTY:711）まで、お電話にてご連絡ください。

Diné Bizaad (Navajo)

D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti’go Diné Bizaad, saad bee 1k1’1n7da’1wo’d66’, t’11 jiik’eh, 47 n1 h0l=, koj8’ h0d77lnih 1-866-766-2583.

Русский (Russian):

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-766-2583 (телетайп: 711).