Program Instructions

Three simple activities, three opportunities to earn rewards!

ANNUAL WELLNESS VISIT

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

HEALTH SURVEY

We'd like to get to know you better. Complete and submit our Health Survey.

LAB WORK

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

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

Three easy steps to earn and redeem your rewards!

1

Choose an activity, in any order you wish. Fill out the activity form, making sure you complete the form in its entirety.

2

Mail the completed activity form to be processed to:
303 W. Madison St., Suite 800 Chicago, Illinois 60606-3389.

3

Repeat this process for all three activities to earn $250 in rewards! Please retain your reloadable card so that rewards can be loaded for each subsequent activity you complete.

Questions? Contact NationsBenefits at 888-282-6853 (TTY: 711). Member Experience Advisors are available 24 hours a day, seven days a week, including holidays.

Participation Rules and Tracking

Participation Rules

Important participation rules. Read carefully.

1. The Activity Forms must be completed in the plan year that they were received. (Example, if the rewards kit was received in 2022, the activities in the kit must be completed in 2022.)

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 illlegible forms may delay processing of a reward. An outreach from us may be required to obtain the information necessary to complete the form for reward processing.

5. **Please note: your Rewards card will be sent to the mailing address you have provided to Lasso Healthcare. If you have not provided a mailing address, the card will be sent to the permanant address on file.**

Activity and Reward Tracking

This section can be used to track when you submit your forms and receive your rewards.

1. **Health Survey**

   Date Activity Form Submitted: _____
   Month Day Year

   Date Reward Received: _____
   Month Day Year

2. **Annual Wellness Visit**

   Date Activity Form Submitted: _____
   Month Day Year

   Date Reward Received: _____
   Month Day Year

3. **Lab Work**

   Date Activity Form Submitted: _____
   Month Day Year

   Date Reward Received: _____
   Month Day Year

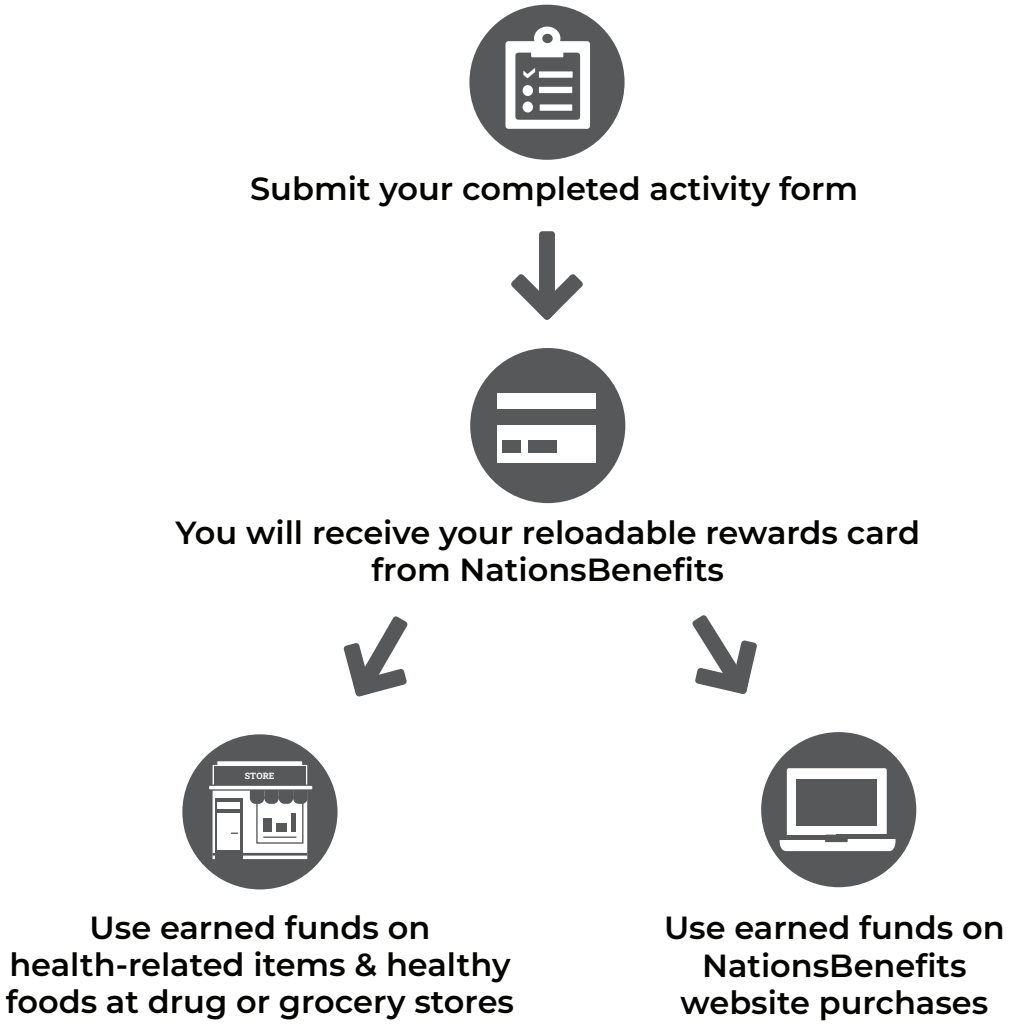
NationsBenefits Information

We've partnered with NationsBenefits to bring enhancements to the Rewards program!

Upon submitting your first completed activity form, you will receive a reloadable debit card from NationsBenefits. We will load the physical debit card with the earned funds for that activity. Each activity after that will trigger earned rewards to be loaded to your account, accessible by the same reloadable card, so make sure to keep it handy!

You will have your own portal through NationsBenefits, where you can log in to check account balances and even purchase goods! When you receive your card, you will find information on the card carrier, which will tell you how to access your personal portal and manage your account.

To better align with our Rewards program, which promotes taking control of your health, you can use your earned rewards towards the purchase of over-the-counter medications and supplements, health-related equipment such as bandages and braces, as well as groceries for a healthy diet.



Questions? Contact NationsBenefits at 888-282-6853 (TTY: 711). Member Experience Advisors are available 24 hours a day, seven days a week, including holidays.

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 Phone Number: _____

Member ID #: _____ Date of Service: _____
Month Day Year

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

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

**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 this calendar year, 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)

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: _____

First Name: _____ Last Name: _____

Gender: ◯ Male ◯ Female ◯ Other Height: ___ ft. ___ in. Weight: _____ lbs.

Race: _____ Ethnicity: _____

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

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, for what? ◯ Accident (e.g., car accident, fall, etc.) ◯ Work related accident ◯ Illness

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

Section 3: Your Medications and Supplements

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

If so, how many? ◯ 1-3 ◯ 4-7 ◯ >7

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

If so, how many? ◯ 1-3 ◯ 4-7 ◯ >7

Section 3: Your Medications and Supplements, continued...

3.3 Have you taken any prescription opioids or narcotics in the last year? ◯ Yes ◯ No *(if No, skip to 3.4)*

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

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

3.4 Do you have multiple providers prescribing medications to you? ◯ Yes ◯ No

Section 4: Your Chronic Conditions

Diabetes

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

If Yes, please choose specific diagnosis: ◯ Prediabetes ◯ Type 1 ◯ Type 2

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: _____

Who do you see to manage your diabetes? Select all that apply. ◯ PCP ◯ Specialist ◯ None

What were your most recent A1C levels? ◯ 5.7-6.4 ◯ 6.5-8.9 ◯ 9+

Have you had an eye exam during the past year? ◯ Yes ◯ No

Cardiovascular

4.2 Blood Pressure:
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)*

Section 4: Your Chronic Conditions, continued...

Cardiovascular, continued

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

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

4.3 Heart:
Have you ever been diagnosed with any of the following heart conditions? Select all that apply. *(If No, skip to 4.4)*

- ◯ Angina (chest pain with exercise)
- ◯ Atrial Fibrillation (irregular heartbeat)
- ◯ Chronic Heart Failure
- ◯ Heart Attack
- ◯ Stroke
- ◯ Other _____

Are you under the care of a medical provider for your heart condition(s)? ◯ Yes, PCP ◯ Yes, Specialist ◯ No

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Lungs

4.4 Have you ever been diagnosed with a chronic lung condition (respiratory)? Select all that apply. *(If No, skip to 4.5)*

- ◯ Asthma
- ◯ Chronic Lung Condition
- ◯ Chronic Obstructive Pulmonary Disease (COPD)
- ◯ Emphysema
- ◯ Pneumonia
- ◯ Tuberculosis (TB)
- ◯ Other _____

Have you been prescribed a preventative prescription for this condition? ◯ Yes ◯ No

Are you under the care of a medical provider for your lung condition(s)? ◯ Yes, PCP ◯ Yes, Specialist ◯ No

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Kidneys

4.5 Have you ever been diagnosed with a serious kidney condition? Select all that apply. *(If No, skip to 4.6)*

- ◯ Kidney failure (nephropathy)
- ◯ Other _____

Are you on dialysis? ◯ Yes ◯ No

If on dialysis, how many times per week are you receiving treatment? ◯ 1-2 ◯ 3-5 ◯ 6-7

Section 4: Your Chronic Conditions, continued...

Kidneys, continued

Are you under the care of a medical provider for your kidney condition(s)? ◯ Yes, PCP ◯ Yes, Specialist ◯ No

Liver

4.6 Have you ever been diagnosed with a liver condition? Select all that apply. *(If No, skip to 4.7)*

- ◯ Cirrhosis
- ◯ Hepatitis
- ◯ Other _____

Are you under the care of a medical provider for your liver condition? ◯ Yes, PCP ◯ Yes, Specialist ◯ 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 currently receiving cancer treatments? ◯ Yes ◯ No

Other Chronic Conditions

4.8 Have you ever been diagnosed with any of the following chronic conditions? Select all that apply. *(If No, skip to 4.9)*

- ◯ ALS
- ◯ Arthritis
- ◯ Autism Spectrum Disorder
- ◯ Crohn's Disease or IBS
- ◯ Cystic Fibrosis
- ◯ Drug/Substance Abuse
- ◯ Eating Disorder
- ◯ Hepatitis
- ◯ Lupus
- ◯ Osteoporosis
- ◯ RSD Syndrome
- ◯ Other _____

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

Section 4: Your Chronic Conditions, continued...

Mental Health

4.9 Have you ever been diagnosed with a mental health disorder? Select all that apply. *(If No, skip to Section 5)*

- ◯ Anxiety
- ◯ Depression
- ◯ Bipolar Disorder
- ◯ Schizophrenia
- ◯ Dementia
- ◯ Other _____

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

Even if undiagnosed, if you have any concerns about anxiety, depression, PTSD, or other mental health issues, we encourage you to speak to your provider.

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

Are you interested in quitting? ◯ Yes ◯ No

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

How many times per week? ◯ 1-2 ◯ 3-5 ◯ 5+

Section 6: Preventive Activities

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

6.2 Have you received 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 6.10)*

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

6.10 Have you been tested for sexually transmitted infections (STIs) in the past 12 months? ◯ Yes ◯ No

Section 7: Durable Medical Equipment (DME)/Lifestyle Tools

7.1 Do you use any of the following equipment? Select all that apply.

◯ Hearing aid ◯ Walker
◯ Glasses ◯ Wheelchair
◯ Oxygen ◯ Other _____

Section 8: Coronavirus (COVID-19)

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

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

Have you been diagnosed with long COVID? ◯ Yes ◯ No

8.2 Have you received the COVID-19 vaccine? ◯ Yes ◯ No

8.3 Have you received the COVID-19 booster? ◯ Yes ◯ No

Section 9: More About You

9.1 How would you rate your overall health? ◯ Above average ◯ Average ◯ Below average

9.2 How would you rate your overall physical ability level? ◯ Above average ◯ Average ◯ Below average

9.3 How would you rate your overall physical functionality? ◯ Above average ◯ Average ◯ Below average

9.4 Do you have any difficulties with the following? Select all that apply.

- ◯ Access to transportation
- ◯ Food preparation
- ◯ Handling finances
- ◯ Housekeeping
- ◯ Laundry
- ◯ Managing your own medications
- ◯ Shopping
- ◯ Using the telephone

9.5 Are you experiencing any of the following? Select all that apply.

- ◯ Anger
- ◯ Depression
- ◯ Fatigue
- ◯ Laundry
- ◯ Loneliness/Social isolation
- ◯ Low life satisfaction
- ◯ Pain
- ◯ Stress

Section 9: More About You, continued...

9.6 Please rate the following:

Home safety	◯ Above average	◯ Average	◯ Below average
Motor vehicle safety	◯ Above average	◯ Average	◯ Below average
Nutrition	◯ Above average	◯ Average	◯ Below average
Oral health	◯ Above average	◯ Average	◯ Below average

9.7 Do you have any concerns about the following? Select all that apply.

- ☐ Bathing
- ☐ Dressing
- ☐ Feeding
- ☐ Grooming
- ☐ Physical ambulation
- ☐ Toileting

Activity Form: Lab Work

Complete Section 1 of this form, then ask your 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 Phone Number: _____

Member ID #: _____

Section 2: To be completed by your 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. Please fill out the section below upon completion of the member's lab work visit.

Lab Provider: _____ Date of Lab Work: ___/___/___

Month Day Year

Lab Provider Signature: _____ Title: _____

Discrimination is Against the Law

Lasso Healthcare 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).