

PPO PARTICIPANTS

HOW TO COMPLETE BIOMETRICS



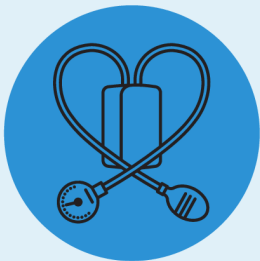
HOW TO COMPLETE BIOMETRICS



For Currently Enrolled Blue Shield PPO Members and their Spouses/Domestic Partners who choose to participate in the Wellness Program (referred to as “Health Care Partnership” or “HCP”) in 2025.



The Wellness Program (HCP) has reduced dependent premiums and out-of-pocket costs for doctor visits, hospital stays, etc. **If you would like to be eligible to participate in the Wellness Program (HCP) for 2025, you and your Spouse/Domestic Partner must complete Wellness Steps individually, including their own Biometric Screening.**



Members can go to Quest Diagnostics or Labcorp to complete Biometrics instead of their primary care doctor.

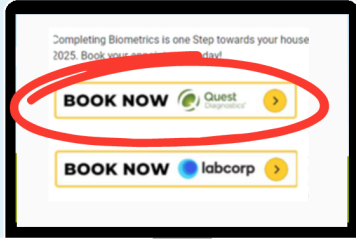
Both Quest and Labcorp offer quick and convenient online scheduling for Biometric screenings without cost.

BIOMETRIC SCREENING INSTRUCTIONS

QUEST DIAGNOSTICS INSTRUCTIONS

Members can go to Quest Diagnostics to complete Biometrics instead of their primary care doctor, without cost.

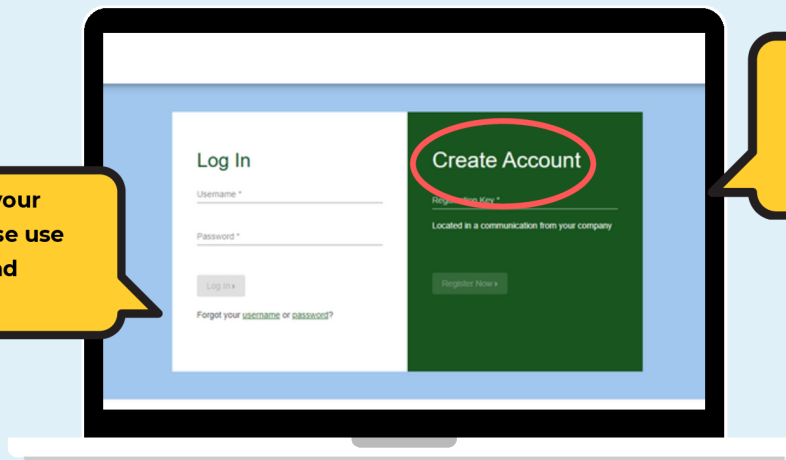
1



Log into your ufcwtrust.com Participant Account. Click on the **"BOOK NOW Quest Diagnostics"** button.

You will be directed to the Quest website. If you already have a Quest account, please log in with your Username and Password.

If you don't remember your Login information, please use the [Forgot username and password link](#) here



NEW USERS ONLY: If you are new to Quest, create an account. For the Registration Key please enter "UFCW"

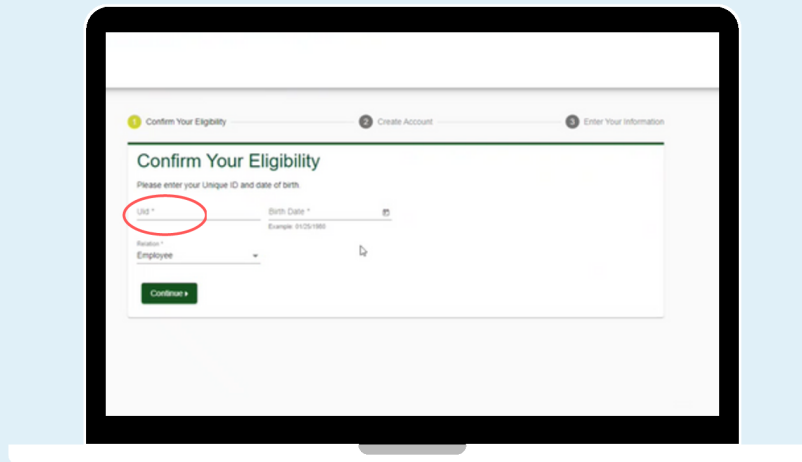
2

If you are and creating an account, you will see the Confirm your Eligibility page.

For Members: the "UID" will be the 9 digits of your SSN + your 8 digit Date of Birth.
(EXAMPLE: 12345678901011970)

For Spouses. the "UID" will be the Member's SSN + Member's 8 digit DOB (NOT your own) with an "S"
(EXAMPLE: 12345678901011970S)

NEW USERS ONLY



Continue to fill out your information. Once your account is created, you will be prompted to make an appointment.

2

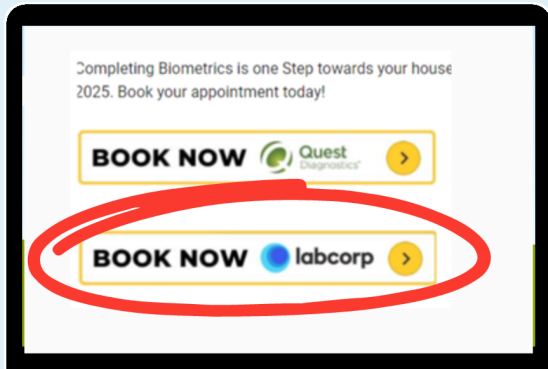
BIOMETRIC SCREENING INSTRUCTIONS

LABCORP INSTRUCTIONS

Members can go to Labcorp to complete Biometrics instead of their primary care doctor, without cost.

1

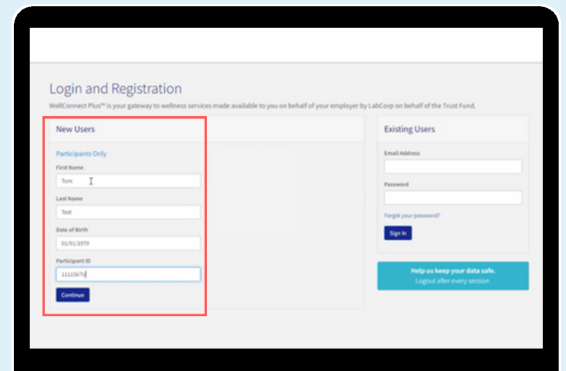
Log into your ufcwtrust.com Participant Account.



Click the **"BOOK NOW Labcorp"** button

2

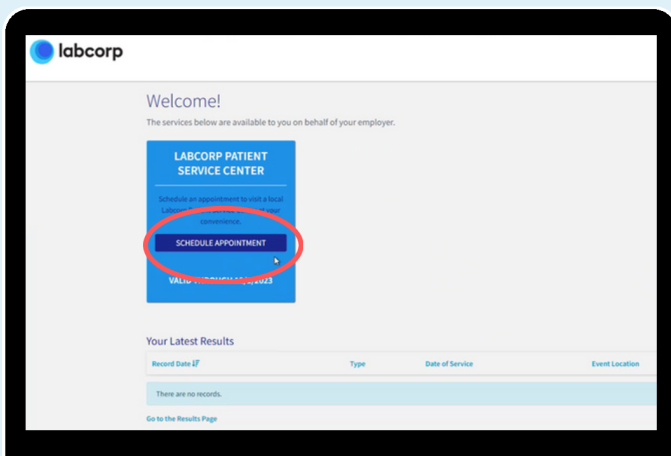
Under "New Users" please fill out your information in the following fields, then click "Continue".



Continue to follow the prompts and fill out your information to register for an account.

3

Once your account is created, you will be prompted to make an appointment, where you can find a location and schedule a time.



Within 2-3 weeks after your test, go to your ufcwtrust.com Participant Account to view your completion status



You will be provided a test requisition form, please bring a paper or digital copy with you to the LabCorp facility.

BIOMETRIC SCREENING INSTRUCTIONS



PLEASE NOTE: Quest and Labcorp will automatically send your results to the Trust Fund Office. ONLY use a paper BIO25 Form and the upload instructions below if you are unable to do the online process for any reason.

The BIO25 biometric screening form will allow your doctor to perform your biometric wellness screening for the 2025 Plan Year.

To use this screening option, laboratory work must be done after January 1, 2024, and results must be received on or before November 22, 2024. Please be aware, your physician may send you to an outside laboratory for biometric testing.

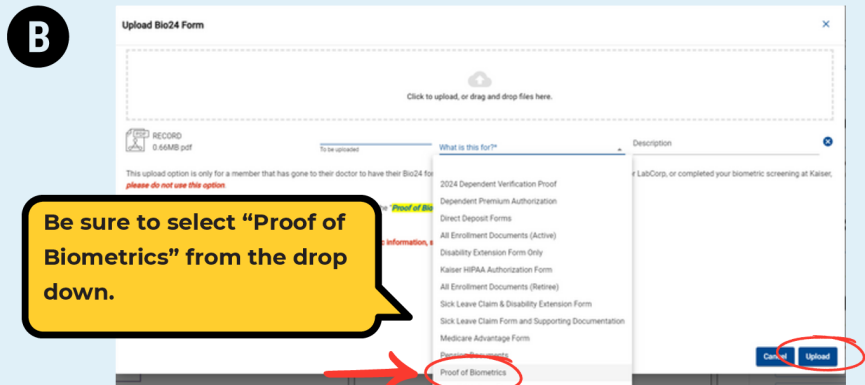
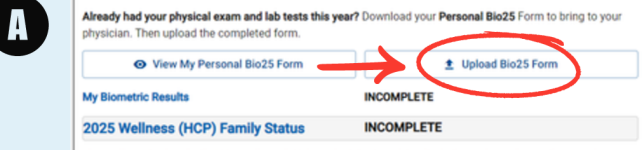
You are responsible for ensuring your completed form is directly uploaded to your TFO Participant Account, complete with all screening values and signatures. Results received in any other format will not be accepted. Please follow these steps carefully:

1 SCHEDULE AN APPOINTMENT WITH YOUR DOCTOR



If you have already had your annual physical for the 2025 Plan Year (meaning you had your physical on or after January 1, 2024), have your physician record your biometrics on the BIO25 form and provide it back to you.

You will then upload the completed BIO25 to your Participant Account on ufcwtrust.com on the Open Enrollment tab.



Please be aware that your physician's office may charge you a fee for a second physical as the Trust Fund will only cover one physical at 100% per calendar year. In addition, your physician may apply a fee for completing the form.

If your physician charges a fee for completing the form, please ask your physician's office to submit the bill for the fee to Blue Shield's address shown on the back of your health plan ID card.

BIOMETRIC SCREENING INSTRUCTIONS

2

PROVIDE YOUR PHYSICIAN THE “BIO25 FORM”



Your Physician must complete the “Physician Office Completes” section of the form, including signature, date, and UPIN/NPI.

The UPIN/NPI is a unique number that identifies your Physician’s office; your Physician will know this number.

3

YOU MUST SIGN AND DATE “PARTICIPANT SIGNATURE” SECTION



You must sign and date the “Participant Signature” section of the enclosed Physician Biometric Screening Form before providing the form to your doctor.

NOTE: Members and Spouses/Domestic Partners must each provide a separate form to their physician.

4



FASTING REQUIRED

It is recommended you fast (not eat or drink anything but water) for at least 12 hours prior to your appointment. Continue taking medication as directed and be sure to drink plenty of water. Lab work must be completed between January 1, 2024, and November 22, 2024.

5

SUBMIT FORM

Your physician must provide the completed form to you. You must upload or mail all documents by November 22, 2024.



MEMBERS AND SPOUSES/DOMESTIC PARTNERS: To upload your completed document(s), log into your Participant Account on ufcwtrust.com and select the “Upload Bio25 Form” button on the Open Enrollment tab.

Choose “Proof of Biometrics” as your document type before uploading. You can also mail the form to 1000 Burnett Avenue, Suite 110 Concord, CA 94520-2000.

Again, you are responsible for ensuring this form is returned on or before November 22, 2024.

FURTHER ASSISTANCE



NOTE: Only completed forms will be processed. If a form is submitted with missing information, you will be required to complete the entire form and resubmit, so please ensure that all items are filled out.



PLEASE NOTE: It will take 5 business days from your BIO25 form upload for processing and approval.

For more information regarding this form please visit ufcwtrust.com.



If you are planning an annual physical with your Primary Care Physician, you can simply take the BIO25 form on the last page and have your physician complete.

You can also download the BIO25 form by logging into ufcwtrust.com, selecting the "View My Personal Bio25 Form" button.

Submit the completed form using the "Upload BIO25 Form" button before November 22, 2024.



If you have questions about the Biometric Health Screening, eligibility, or enrollment in medical plan benefits, please contact the Trust Fund Office at 1-800-552-2400. Receipt of this notice does not constitute a determination of your eligibility for benefits.

BIO25 – PROVIDER DATA ENTRY FORM

GENERAL INFORMATION

PLEASE PRINT CLEARLY AND STAY WITHIN THE BOXES BELOW

PARTICIPANT (PERSON BEING MEASURED) INFORMATION – Completion required.

First Name: [Grid of 20 boxes]

Must match the name on record for your health benefits.

Last Name: [Grid of 20 boxes]

DOB (MM/DD/YYYY): [Grid of 8 boxes]

Member ID#: [Grid of 10 boxes] U [Grid of 1 box]

Spouses/Domestic Partners have a distinct Member ID# that is separate from the Subscriber's Member ID#. Enter the Member ID# of the person being measured.

If you do not know your Member ID#, you must complete the field for SSN below.

SSN: [Grid of 9 boxes]

If you have entered your Member ID# above, you may leave the field for SSN blank.

Important: This form is ONLY for current UEBT/UCBT Members and Spouses/Domestic Partners who are completing their Wellness Steps for 2025 benefits.

If you are the Spouse of a Member, you must submit your completed GINA Agreement to the Trust Fund Office before completing and submitting this form

By submitting this form, I am authorizing my physician to report the laboratory and biometric results to UFCW & Employers Trust, LLC for my Biometric Health Screenings, and for UEBT/UCBT to collect such information. If I am a Participant in the UEBT/UCBT Plan because I am the Spouse of a Member, I further acknowledge that by agreeing to this authorization, I am providing information regarding my current or past health status (or manifestation of disease or disorder) and that I authorize the use of this information for the purposes described in the Biometric Screenings Instructions.

- 1. Please review the Biometric Screenings Instructions to verify you need biometric screenings tests prior to having any done.
2. You, the Participant, are responsible for meeting all program deadlines. You, the Participant, must collect this form from your physician or clinician and submit to UFCW & Employers Trust, LLC, as prescribed. Only one physician form can be submitted per person.
3. See the program description in your enrollment materials for more details. Please keep a copy of this physician complete form for your records.

Participant's Signature: _____ Date (MM/DD/YYYY): [Grid of 8 boxes]

BIO25 – Biometric Screenings Form

BIO25 – PROVIDER DATA ENTRY FORM

GENERAL INFORMATION

Participant Last Name:

DOB (MM/DD/YYYY):

FOR PROVIDER OR OFFICE STAFF USE ONLY BELOW THIS LINE

Blood Pressure	Cholesterol	Glucose
<input type="text"/> <input type="text"/> <input type="text"/> Systolic <input type="text"/> <input type="text"/> <input type="text"/> Diastolic Test Date (MM/DD/YYYY): <input type="text"/> <input type="text"/> <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"/> TRI: <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"/> Total: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Total/HDL Ratio: <input type="text"/> . <input type="text"/> <input type="text"/> Test Date (MM/DD/YYYY): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Fasting Glucose: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> -OR- A1c (Fasting or Non-fasting): <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> Test Date (MM/DD/YYYY): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

BODY MEASURE	NICOTINE USER?
Height: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (in.) Weight: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (lbs.) Test Date (MM/DD/YYYY): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Y <input type="checkbox"/> N

NOTE: Facility and agent name must be printed in the boxes.

I certify these values are correct.

Facility Name:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Certifying Agent First Name:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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NPI#:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Today's Date: (MM/DD/YYYY)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Signature: _____

NOTE: Use this area for office or facility stamp

Please upload this form to your Participant Account on ufcwtrust.com, or fax this form to 925-746-7549

For more information, call the UFCW Trust Fund Office Health and Welfare Services Department at 800-552-2400