Employee Wellness Program

Wellness Program 2019
Kettering City Schools

Kettering Employees,

Quality, affordable health care doesn't just happen. The choices we make have a significant impact on our current and future costs. To help us make the best choices, we are pleased to continue our wellness initiative powered by Kettering Health Network. As an enrolled member of our medical benefit program, you and your spouse are eligible to participate and take advantage of the benefits offered by this new streamlined program. As much as 75 percent of all medical claims costs are directly related to choices: our lifestyle choices, our pharmacy choices, even where we choose to utilize medical services. By educating, promoting and rewarding healthy lifestyle and smart consumer choices, we believe that together we can continue to provide you with the best medical coverage at the lowest cost for you and your families.

Here's How it Works!

Beginning with the new 2019 plan year, (January 1 - December 31) each eligible adult participant and their spouse will be asked to complete an annual physical and biometric screening with their Primary Care Physician.

- **Little Clinic or similar visits will not be accepted, you must go to your PCP.**
- **Your insurance plan covers a wellness visit once per calendar Year, therefore you may go to your PCP any time during the year. It does not have to be 365 days from your last visit. Physician's schedules fill up the last quarter of the year. Plan accordingly and schedule early.**

Kettering Health Network will be the vendor that is collecting and storing all of the information just like the 2018 plan year. Individual information will not be shared with KCS staff. Only aggregate data or "group" level data will be shared.

Each employee and each spouse must fill out their own forms. Make sure to fill out all information, especially checking the box if you are the employee or the spouse.

KCS Completion Incentives

To be eligible for your incentive payout, simply complete these required activities:

Annual Physical **with PCP**
Biometric Screening **with PCP**

Incentive payout:
Activities completed in 2019 will earn you the incentive payout in 2020.

Deadline: All employees (and spouses if applicable) must turn in forms to KHN by **12/31/19.**

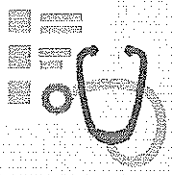
KETTERING Health Network.

If you or your spouse enroll in the KCS health plan after September 30, 2019, but no later than January 1, 2020, you will have until March 31, 2020 to complete your wellness activities and still receive your incentive in 2020.

Kettering Health Network Support

Phone: 800.888.8362
Hours: Mon. - Fri., 8am-4:30pm EST
Email: KHNwellness@ketteringhealth.org

What Activities Are Required to be Eligible to Receive Your Incentive?



Biometric Screening with PCP

Annual Physical with PCP

= **INCENTIVE**

Biometric Screenings

Biometric screenings are used to identify individuals who may have risk factors, such as heart disease, diabetes, metabolic syndrome and more. After reviewing your results, your physician may offer recommendations on how to reduce risk factors, follow-up care, or lifestyle changes.

Member instructions:

- Receive your 2019 Employee Wellness Registration Form and 2019 Wellness Exam Reporting Form.
- Schedule your exam **anytime** between: **January 1, 2019 and December 31, 2019 (the sooner the better).**
- Each Employee and Each Spouse (if applicable) must fill out a 2019 Employee Wellness Registration Form and 2019 Wellness Exam Reporting Form
- Take the form with you to be completed by your physician.

FINAL STEP to complete requirements – Send registration form and wellness exam form to KHN.

Email or Fax the forms to Kettering Health Network Community Outreach department.

Email: KHNwellness@ketteringhealth.org

Fax: (937) 522-9985

Don't forget your Recommended Preventive Screenings – discuss with your Primary Care Physician during your Annual Physical

Breast Cancer Screening
(Women, age 50-74)
Method: Mammogram
Interval: Every 2 years

Cervical Cancer Screening
(Women, age 21-65)
Method: Pap test
Interval: Every 3 years
-OR-
Method: Pap test with HPV co-testing
Interval: Every 5 years

Colorectal Cancer Screening
(Women/Men age 50-74)
Method: Fecal occult blood test
Interval: Every year
-OR-
Method: Sigmoidoscopy
Interval: Every 5 years
-OR-
Method: Colonoscopy
Interval: Every 10 years

2019 Employee Wellness Registration Form

PLEASE PRINT CLEARLY

Employee Wellness Program

Employer: **Kettering City Schools** Select One: Male O Female O

Your First Name: _____ Your Last Name: _____

Your Date of Birth: _____/_____/_____ Social Security Number (last 4) _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Daytime Phone: _____-_____-_____ Email: _____

Are you: KCS Employee O Covered Spouse O KCS Work Location (or Department): _____

Select Plan Coverage: Single O Family O Member Number (from Insurance Card): _____

If on the Family Plan, please list spouse's first and last name: _____

Select Preferred Means of Contact: Phone O Email O

My participation in Kettering City School's (KHN) Employee Wellness Program is voluntary. I understand that the responsibility for initiating a follow-up examination to confirm results of any physical screening and obtaining professional medical assistance is mine alone, and not that of my health plan, employer or KHN.

My employer and/or health plan will have access to and review aggregate data (my individually identifiable medical information combined with those of other participants in the Program that does not personally identify me) to assess population trends. I consent to my health plan/employer's receipt of aggregate data as described in the prior sentence. I further consent to receipt of such aggregate data by my health plan/employer/ wellness advisor. My health plan/employer will not receive nor have access to my individually identifiable medical information as part of the Program. I further consent to the disclosure of my personally identifiable biometric data/report by Kettering Health Network to the third party data analytic vendor specified by my health plan/employer in order for such vendor to determine my eligibility for medical insurance premium discounts and/or for data aggregation as described above in this form.

I understand that should I participate in the biometric screening, it is not a substitute for a thorough clinical examination and/or consultation with my physician. I understand that the information derived from this screening is meant to provide preliminary information only and that in order to obtain the full benefit from the program, it is important that I follow-up with my physician or other health care practitioner. I understand that a screening that is read as normal is still not a guarantee that no abnormalities are present. I understand that my health is my responsibility. The responsibility of initiating any follow-up examination for abnormalities identified at the KHN Kettering Health Outreach screening lies with me as the responsible person, not with the participating organization. I hereby release KHN, its employees, officers, directors, agents, contractors, and volunteers from all claims, liabilities, damages, costs, and expenses related to the screening process and from any inaccuracies or errors in the screening results or recommendations. I understand that my personal results will also be shared with my primary care physician for continuum of care purposes, should the health-screening test(s) or service(s) show that any high-risk abnormalities are present. I do give my permission for my screening results to be shared with KHN departments responsible for tracking program outcomes. I give permission for KHN employees to use my contact information to promote future educational programs, seminars, and/or screenings.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness pro- gram, nor may you be subjected to retaliation if you choose not to participate.

I affirm that I have read, understand and agree to the terms set forth above and I wish to participate in the Employee Wellness Program on the terms specified.

***Signature of Participant:** _____ ***Date:**_____

Kettering Health Network Release of Medical Information

As a participant of the Kettering Health Network Wellness Program I,_____,
(Print your full name)

hereby consent to the disclosure of my biometric screening results by my primary healthcare provider,

_____, to Kettering Health Network.
(Print name of Primary Care Provider)

Submit both Registration Form & Wellness Exam Form together:

- Scan and email to KHNwellness@ketteringhealth.org
- Send to secure fax: (937) 522-9985

KETTERING Health Network

Questions? Contact KHN Community Outreach at 1-800-888-8362

2019 Wellness Exam Reporting Form

Employee Wellness Program

PLEASE PRINT CLEARLY

Employer: **Kettering City Schools** Date of Birth: _ _ / _ _ / _ _ _ _

First Name:_____ Last Name:_____

Are you: KCS Employee ○ Covered Spouse ○ Select Plan Coverage: Employee ○ Family ○

If on the Family Plan, please list your spouse's first and last name:_____

Daytime Phone: _____ - _____- _____ Email:_____

Select Preferred Means of Contact: Phone ○ Email ○

- Please schedule an appointment with your primary care physician. Your primary healthcare provider needs to complete all information with an * in front of it.
- All testing must be completed between January 1, 2019 and December 31, 2019.

Please note - to ensure a claim is filed as a preventive service and thus not billed to the patient, it MUST meet the standards required by United Healthcare. You can review qualifying preventive services by visiting www.uhcpreventivecare.com.

BIOMETRIC MEASURES	VALUE	TEST DATE (Month/Day/Year)
* Waist Circumference (inches)		
* HDL Cholesterol		
* LDL Cholesterol		
* Triglyceride Level		
* Total Cholesterol		
* Glucose – Fasting		
Hemoglobin A1C (if physician recommended)		

Wellness Exam Confirmation

Type of Service Provided: **Complete Annual Physical** *Date of Service: _ _ / _ _ / _ _ _ _

BIOMETRIC MEASURES	VALUE	TEST DATE (Month/Day/Year)
* Height (feet, inches)		
* Weight (pounds)		
* Systolic Blood Pressure		
* Diastolic Blood Pressure		

* On blood pressure medication? YES ○ NO ○

***Healthcare Provider (print name & location):**_____

_____

***Signature of Healthcare Provider:** _____ ***Date:** _____

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