Healthy Hamilton
Fort Hamilton Hospital

2019 Living Well Program Overview and Incentives

The City of Hamilton continues to partner with Kettering Health Network to promote the health and wellness of employees and their families. Employees enrolled in the City of Hamilton's health benefit plan are eligible to receive a contribution to their HSA (or HRA, when applicable) account by participating in the Living Well Program!

Health Plan Coverage	Employee Only	Employee + One	Family
Potential Account Funding Available	$800	$1525	$1525

Living Well Program Requirements for EMPLOYEE & COVERED SPOUSE:

1. Complete a **Tobacco Affidavit**. See page 2 for additional details.

   NEW

   40% ($320 Employee Only / $610 Employee + One / $610 Family) of the HSA/HRA contribution is contingent on being tobacco-free. If you or your spouse are not tobacco-free, you have the option of completing a **Reasonable Alternative** to receive this portion of the funding. Living Well Program participants that are not tobacco-free and have not completed the Reasonable Alternative will forfeit 40% of the account funding.

2. Complete an **Annual Preventive Physical** with a Primary Care Physician between July 1, 2018 and June 30, 2019, and ask your provider to complete their portion of the **Exam Reporting Form.** See page 3 for additional details.

3. Complete a **Biometric Screening or Lab Test Blood Draw** between July 1, 2018 and June 30, 2019, and ask your provider to complete their portion of the **Exam Reporting Form.**

   Based on the results of your Biometric Screening or Lab Test Blood Draw, completion of a **Reasonable Alternative** is required if you are found to have Metabolic Syndrome.

   See pages 3 and 4 for additional details.

4. Complete the Living Well 2019 **Registration Form**.

5. Complete the **Health Risk Assessment** online through Kettering Health Network. Link to the survey and instructions will be sent to your City email address. See page 5 for additional details.
   ***** This requirement is only applicable for the Employee and NOT the covered spouse.***

6. Return all completed forms to Kettering Health Network by June 30, 2019. This includes the **Tobacco Affidavit**, the **Registration Form,** the **Exam Reporting Form,** proof of completion of the **MetS Reasonable Alternative** *(when applicable)* and proof of completion of the **Tobacco Reasonable Alternative** *(if desired)*.

2019 Account Funding:

The City will provide employees who **COMPLETE** the Living Well program requirements with the HSA/HRA funding according to the schedule outlined in the table to the right. Completion includes all requirements being completed by the covered employee, and the employee's spouse *(if applicable).*

*** Contributions will be distributed to qualifying employees in a single payment. Employees will receive their HSA/HRA contribution when **ALL** program requirements have been completed according to the schedule at the right. You will NOT be eligible for any contribution if **ALL** program requirements are not met. ***

All Requirements Completed By	HSA/HRA Funds Distributed
January 31	February
March 31	April
May 31	June
June 30	July

2019 Living Well Program Tobacco Definition

1. Complete a **Tobacco Affidavit**.

   40% ($320 Employee Only / $610 Employee + One / $610 Family) of the HSA/HRA contribution is contingent on being tobacco-free. If you or your spouse are not tobacco-free, you have the option of completing a **Reasonable Alternative** to receive this portion of the funding. Living Well Program participants that are not tobacco-free and have not completed the Reasonable Alternative will forfeit 40% of the account funding.

"Use of tobacco" means all uses of tobacco, including inhaling, exhaling, burning, vaping, or carrying any lighted cigar, cigarette, pipe, alternative nicotine product, other lighted smoking device or papers for burning tobacco, or any other plant; chewing tobacco snuff, or any other matter or substances that contain tobacco within the last thirty (30) days.

**** Future **Living Well Program** requirements will require that participants not "use" tobacco within the prior six (6) months to be considered tobacco-free. ****

"Alternative nicotine product" means an electronic cigarette or any other product or device that consists of or contains nicotine that can be ingested into the body by any other means, including, but not limited to, chewing, smoking, absorbing, dissolving, or inhaling. Nicotine gum, nicotine patches, or any other nicotine replacement therapy aids are excluded.

To be considered a non-tobacco user and eligible for 40% of the 2019 Living Well Program contribution:

- Covered employees (and eligible spouse's) have not used any tobacco product for the last 30 days and are considered tobacco-free

  OR

- Covered employees (and/or eligible spouse's) have used tobacco in the last 30 days, but have provided proof of completion of the Reasonable Alternative

City of Hamilton employees and spouses covered by the City's 2019 health benefit plan who are not tobacco-free are required to complete the following reasonable alternative in order to qualify for the HSA/HRA funds contingent on this factor.

- Quit For Life tobacco cessation program available through UnitedHealthcare
- Call (866)QUIT-4-LIFE or visit www.quitnow.net to enroll in the program
- At least five (5) telephonic sessions with a Quit Coach must be completed
- Participants should request a certificate of completion from their Quit Coach upon completing five (5) coaching sessions.
- To complete the Reasonable Alternative by the deadline, we recommend starting no later than April 1, 2019
- Completion certificates should be returned to Kettering Health Network with the rest of the 2019 Living Well Program materials
- Call Kettering Health Network with questions: (800)888-8362

2019 Living Well Program Annual Preventive Physical and Biometric Screening

2. Complete an **Annual Preventive Physical** with a Primary Care Physician between July 1, 2018 and June 30, 2019, and ask your provider to complete their portion of the **Exam Reporting Form**. See page 4 for additional details.

   AND

3. Complete a **Biometric Screening or Lab Test Blood Draw** between July 1, 2018 and June 30, 2019, and ask your provider to complete their portion of the **Exam Reporting Form**.

   Based on the results of your Biometric Screening or Lab Test Blood Draw, completion of a **Reasonable Alternative** is required if you are found to have Metabolic Syndrome.

About your Annual Preventive Physical:

- This should NOT be completed at a clinic (such as the Little Clinic), but at a Primary Care Physician.
- If you do not have a primary healthcare provider, you can find a healthcare provider in the United Healthcare network by visiting www.uhc.com or by calling (844)2-KHNPHA.
- If you already had a physical after July 1, 2018 you do not need to schedule another visit. Request that your healthcare provider complete the Exam Reporting Form for submission.
- When scheduling your physical, you may want to check if you can complete your biometric screening or lab work prior to your physical. Your healthcare provider can then address your results at your appointment, and could save you from needing to return to your healthcare provider's office a second time.

Biometrics on the Exam Reporting Form may be completed by:

- Attending an onsite biometric screening event offered by Kettering Health Network (dates TBA).
- Completing a lab test blood draw with an order from your healthcare provider.

Helpful Program Information

- Under the City of Hamilton's UnitedHealthcare health benefit plan, if coded as preventive, an annual physical and biometric screening/lab work can be obtained at zero cost to plan members. To be billed as preventive, the correct billing code needs to be used by the healthcare provider's office. Employees and covered spouses may be charged if they already have a diagnosis.
- **To ensure a claim is filed as preventive and thus covered at no cost, it MUST meet the standards set by UnitedHealthcare. Review qualifying preventive services by visiting www.uhcpreventivecare.com.**
- In order to receive UnitedHealthcare coverage, preventive physicals and lab work must be completed by a healthcare provider and laboratory that are part of the UnitedHealthcare health benefit plan network. To find healthcare providers and/or labs that are in network, visit www.myuhc.com.

UnitedHealthcare Network Lab Facilities:

For the most up-to-date listing of in-network lab locations, visit www.myuh.com.

To complete the Exam Reporting Form, you may complete a lab test blood draw with an order from your healthcare provider at an in-network lab, or you may attend an onsite biometric screening event offered by Kettering Health Network (dates TBA).

2019 Living Well Program
Metabolic Syndrome

Metabolic Syndrome (MetS)

Metabolic Syndrome is a group of metabolic risk factors that exist in one person. Some underlying causes of this syndrome that give rise to the metabolic risk factors include being overweight or obese, having insulin resistance, being physically inactive, and/or genetic factors. Individuals with Metabolic Syndrome have a higher risk of diseases related to fatty buildups in artery walls, such as coronary heart disease, and are more likely to develop type 2 diabetes.

The presence of three (3) or more of the following risk factors are used as criteria to identify the presence of Metabolic Syndrome in individuals:

- Central obesity, measured by waist circumference (> 40 inches for men, > 35 inches for women)
- Fasting blood triglycerides ≥ 150 mg/dL
- Low HDL cholesterol levels (< 40 mg/dL for men, < 50 mg/dL for women)
- Elevated blood pressure ≥ 130/85 mm Hg
- Fasting glucose ≥ 100 mg/dL

City of Hamilton employees and spouses covered by the City's 2019 health benefit plan, who have three (3) or more Metabolic Syndrome risk factors are considered MetS. These participants are required to complete one (1) of the following alternatives in order to receive the portion of the HSA/HRA funds contingent on this factor.

- **Engage with your primary care physician on a personal health plan**
  - Individuals who choose this option must submit the **Physician Release Form** to Kettering Health Network with a signature from their primary care physician no later than June 30, 2019

OR

- **Complete Naturally Slim, a 10 week online weight loss program**
  - This program involves one (1) online session per week for ten (10) weeks and is a clinically proven solution to help individuals reduce Metabolic Syndrome risk through weight loss. Individuals who choose this option must contact Kettering Health Network to receive program enrollment information. Kettering Health Network can be contacted by calling 1-800-888-8362 or by emailing healthyhamilton@ketteringhealth.org.

  - Individuals must also submit a **certificate of completion** (provided at the end of the 10th session) to Kettering Health Network no later than June 30, 2019

  - To complete the Reasonable Alternative by the deadline, we recommend starting no later than April 1, 2019

5. Complete the **Health Risk Assessment** online through Kettering Health Network. Link to the survey and instructions will be sent to your City email address.
   **** This requirement is only applicable for the Employee and NOT the covered spouse.**

2019 Online Health Risk Assessment Instructions

One requirement of your 2019 Living Well Program is to complete an online Health Risk Assessment. **This is the only requirement that applies only to the employee and not the covered spouse.**

As a reminder, all Living Well Program requirements must be completed to earn your 2019 HSA/HRA contribution. Please reference the 2019 Living Well Program packet to review complete guidelines for the program. This packet can be found on the City's website (hamilton-city.org) by navigating to Government > Employee Portal > Benefits > Health Benefits, and then scrolling down to the Living Well section.

The online assessment consists of approximately 60 questions regarding health and wellness habits. This survey will provide a more comprehensive wellness picture by combining both biometric information and health habits. Kettering Health Network will use this information to better shape future wellness initiatives for City employees.

Follow the directions below for signing in and completing the online assessment.

As with all components of your wellness program, the individual data collected by Kettering Health Network is confidential.

To access the online Health Risk Assessment click on the link below or copy and paste it into your browser.

https://wellsuite.com/ketteringmc/ws/default.aspx?grid=ef497aa24e1b

If you do not have an account or cannot remember your log-in information from when you completed the assessment in 2018, click " I don't have an account – *Sign Up"* located below the log-in button.

Write down your log-in information for future use.

After signing up, click on Personal Wellness Profile on the left under "My Health Tools". This will take you to the profile. Please go through each page and save at the end. You can view and print your profile at the end if you wish.

Questions? Contact KHN Community Outreach at (800)888-8362 or via email at healthyhamilton@ketteringhealth.org

Healthy Hamilton
Fort Hamilton Hospital

2019 Living Well Program Tobacco Affidavit

PLEASE PRINT CLEARLY

Employer: City of Hamilton Select One: Male ○ Female ○

First Name: _____ Last Name: _____

Are you: City Employee ○ Covered Spouse ○ City Work Location (or Department): _____

Plan Coverage: Single ○ Employee+1 ○ Family ○ Social Security Number (last 4): _____

If Employee+1 or Family Plan, list your spouse's first and last name: _____

Date of Birth: _ _ / _ _ / _ _ _ _ Member Number (from Insurance Card): _____

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

Daytime Phone: _____ Email: _____

Preferred Means of Contact: Phone ○ Email ○

"Use of tobacco" means all uses of tobacco, including inhaling, exhaling, burning, vaping, or carrying any lighted cigar, cigarette, pipe, alternative nicotine product, other lighted smoking device or papers for burning tobacco, or any other plant; chewing tobacco snuff, or any other matter or substances that contain tobacco within the last thirty (30) days.

**** Future **Living Well Program** requirements will require that participants not "use" tobacco within the prior six (6) months to be considered tobacco-free. ****

"Alternative nicotine product" means an electronic cigarette or any other product or device that consists of or contains nicotine that can be ingested into the body by any other means, including, but not limited to, chewing, smoking, absorbing, dissolving, or inhaling. Nicotine gum, nicotine patches, or any other nicotine replacement therapy aids are excluded.

To be considered a non-tobacco user and eligible for 40% of the 2019 Living Well Program contribution:

- Covered employees (and eligible spouse's) have not used any tobacco product for the last 30 days
- Covered employees (and eligible spouse's) that have used tobacco in the last 30 days, but have provided proof of completion of the Reasonable Alternative

Please mark your designation below:

I have read and understand what constitutes tobacco use. I herby confirm:

❑ **YES** – I and my covered spouse are tobacco-free.

❑ **YES** – I am not tobacco-free, but will complete the Reasonable Alternative. I understand it is my responsibility to return a completion certificate to Kettering Health Network by the program deadline. My spouse is tobacco-free.

❑ **YES** – I am tobacco-free. My covered spouse is not tobacco-free, but will complete the Reasonable Alternative. I understand it is my responsibility to return a completion certificate to Kettering Health Network by the program deadline.

❑ N**O** – Either myself or my spouse are not tobacco-free, and we will not complete the reasonable alternative. I understand that 40% of the HSA/HRA contribution is contingent on this requirement, and by selecting this option I do not qualify for 40% of the HSA/HRA contribution.

I certify that this information is true and correct. I understand that providing false information on this form would be considered a violation of my employer's standards of conduct as falsification of a form, and that this may result in disciplinary action up to and including termination of employment as determined by The City of Hamilton.

Signature of Participant: _____ Date: _____

Please submit completed form:

- Scan and email to healthyhamilton@ketteringhealth.or
- Send via secure fax: (513)867-690

Healthy Hamilton
Fort Hamilton Hospital

2019 Living Well Program Registration Form

PLEASE PRINT CLEARLY

Employer: City of Hamilton Select One: Male ○ Female ○

First Name: _____ Last Name: _____

Are you: City Employee ○ Covered Spouse ○ City Work Location (or Department): _____

Plan Coverage: Single ○ Employee+1 ○ Family ○ Social Security Number (last 4): _____

If Employee+1 or Family Plan, list your spouse's first and last name: _____

Date of Birth: _ _ / _ _ / _ _ _ _ Member Number (from Insurance Card): _____

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

Daytime Phone: _____ Email: _____

Preferred Means of Contact: Phone ○ Email ○

My participation in Kettering Health Network's (KHN) Living Well 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.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or alternative standard by contacting Lauren Gersbach at lauren.gersbach@hamilton-oh.gov or 513-785-7278.

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.

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

Signature of Participant: _____ Date: _____

Kettering Health Network Release of Medical Information

As a participant of the Kettering Health Network Living Well Program I, (*Print Full Name*) _____
hereby consent to the disclosure of my biometric screening results by my primary healthcare provider,
(Print name of Primary Care Provider) _____
to Kettering Health Network.

Submit this Registration Form and the Exam Reporting Form together:

- Scan and email to healthyhamilton@ketteringhealth.org
- Send via secure fax: (513)867-6900

KETTERING Health Network

Healthy Hamilton
Fort Hamilton Hospital

2019 Living Well Program Exam Reporting Form

PLEASE PRINT CLEARLY

Employer: City of Hamilton Select One: Male ○ Female ○

First Name: _____ Last Name: _____

Are you: City Employee ○ Covered Spouse ○ City Work Location (or Department): _____

Plan Coverage: Single ○ Employee+1 ○ Family ○ Social Security Number (last 4): _____

If Employee+1 or Family Plan, list your spouse's first and last name: _____

Date of Birth: _ _ / _ _ / _ _ _ _ Member Number (from Insurance Card): _____

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

Daytime Phone: _____ Email: _____

Preferred Means of Contact: Phone ○ Email ○

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)		

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: _____

Questions? Contact KHN Community Outreach at (800)888-8362 or via email at healthyhamilton@ketteringhealth.org

Submit this Registration Form and the Exam Reporting Form together:

- Scan and email to healthyhamilton@ketteringhealth.org
- Send via secure fax: (513)867-6900

KETTERING Health Network

Healthy Hamilton
Fort Hamilton Hospital

2019 Living Well Program Physician Release Form

PLEASE PRINT CLEARLY

Employer: City of Hamilton Select One: Male ○ Female ○

First Name: _____ Last Name: _____

Are you: City Employee ○ Covered Spouse ○ City Work Location (or Department): _____

Plan Coverage: Single ○ Employee+1 ○ Family ○ Social Security Number (last 4): _____

If Employee+1 or Family Plan, list your spouse's first and last name: _____

Date of Birth: _ _ / _ _ / _ _ _ _ Member Number (from Insurance Card): _____

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

Daytime Phone: _____ Email: _____

Preferred Means of Contact: Phone ○ Email ○

Metabolic Syndrome

Metabolic Syndrome is a group of metabolic risk factors that exist in one person. Some underlying causes of this syndrome that give rise to the metabolic risk factors include being overweight or obese, having insulin resistance, being physically inactive, and/or genetic factors. Individuals with Metabolic Syndrome have a higher risk of diseases related to fatty buildups in artery walls, such as coronary heart disease, and are more likely to develop type 2 diabetes.

The presence of three (3) or more of the following risk factors are used as criteria to identify the presence of Metabolic Syndrome in individuals:

WAIST CIRCUMFERENCE	> 40 inches for men, > 35 inches for women
FASTING BLOOD TRIGLYCERIDES	≥ 150 mg/dL
HDL CHOLESTEROL	< 40 mg/dL for men, < 50 mg/dL for women
BLOOD PRESSURE	≥ 130/85 mm Hg
FASTING GLUCOSE	≥ 100 mg/dL

City of Hamilton employees and spouses covered by the City's 2019 health benefits plan, who have three (3) or more Metabolic Syndrome risk factors, are required to complete a reasonable alternative in order to receive the 2019 HSA/HRA disbursement. Engaging with your primary care physician on a personal health plan will be accepted as a reasonable alternative.

Instructions for Primary Care Physician

By signing below, I_____confirm that based on the biometrics included as part of
(Print name of Primary Care Provider)
the City of Hamilton's Living Well Program Exam Reporting Form, my patient has three (3) or more Metabolic Syndrome risk factors, as defined above. I am working with my patient on a plan to improve their out-of-range risk factors and thus improve their health. Engagement in this plan by my patient will suffice as a reasonable alternative for the City of Hamilton's Living Well Program.

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

Submit this Registration Form and the Exam Reporting Form together:
- Scan and email to healthyhamilton@ketteringhealth.org
- Send via secure fax: (513)867-6900

KETTERING Health Network

Healthy Hamilton
Fort Hamilton Hospital

2019 Living Well Program Checklist

Submit Your Forms:

All program components must be completed and submitted to Kettering Health Network by June 30, 2019.

It is preferred that you send the entire completed packet at one time. By providing your email address on the forms, we can confirm receipt of your packet.

Please keep a copy of all forms for your files.

Submit all completed paperwork together to Kettering Health Network:

- Via email: healthyhamilton@ketteringhealth.org
- Via secure fax: (513)867-6900
- Via mail: KHN Community Outreach, Attn: Laurie Jakoplic, 2145-A N. Fairfield Rd, Beavercreek, OH 45431

Questions about the Living Well Program?

- Contact Laurie Jakoplic at 1-800-888-8362.

1. **Tobacco Affidavit** and proof of **Reasonable Alternative** completion *(if desired)* ☐

2. **Annual Preventive Physical** ☐

3. **Biometric Screening or Lab Test Blood Draw** and proof of **Reasonable Alternative** completion *(if applicable)* ☐

4. **2019 Program Registration Form** and **Exam Reporting Form*** ☐

5. **Health Risk Assessment** (online) ☐

*If your physician completed your biometric measures in addition to the annual physical these two forms may be on one combined form. If you receive your physical separately from your biometrics then two Exam Reporting Forms will need to be submitted (one for the Annual Preventive Physical and one for the biometrics).