PLEASE READ REGARDING 2024 WELLNESS YEAR The Wellness Program is not mandatory. However, Non-Medicare Active and Retired Participants and their spouses are encouraged to participate in the Wellness Program. If you do not meet the acceptable biometric ranges, you may complete telephonic coaching. All telephonic coaching for this period must begin no later than January 31, 2025, as the coaching must be completed no later than March 31, 2025. CMS may be contacted by calling 262-563-6460. It is your responsibility to plan your coaching sessions ahead of the completion date.

Eligible Participants and their spouses participating in the Wellness Program may choose one of the two incentive options, the Gift Card or the 2024 Deductible Waiver. Please note, only Active Participants and their spouses are eligible for the Deductible Waiver option and if you are married, both you and your spouse must participate and elect the Deductible Waiver option.

If you have participated in a Health Screening or submitted a form to your Primary Care Physician during the 4th Wellness Year of January 1, 2024 through December 31, 2024, you will not be eligible to attend another Health Screening during this period. If you are unsure if you and/or your spouse have health coverage at the time of an event, you should contact the Health Fund Office prior to scheduling an appointment on the web calendar.

- If you choose to have your biometrics performed with your Primary Care Physician (PCP), you MUST use the "Wellness Forms 2024" found on the website under Forms or you may contact the Health Fund Office.
- If you choose to have your biometric screening at an On-Site Wellness Event the Wellness Biometric Screening forms will be provided upon arrival. (OnSite locations, dates and times when determined can be found on the Notices mailed to you).

IMPORTANT: All biometric results performed during the period of January 1, 2024 through December 31, 2024 MUST be completed using the Primary Care Physician (PCP) Consent and Authorization forms. These forms MUST be submitted to CMS no later than January 31, 2025. CMS contact information can be found on the PCP form.

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WISCONSIN LABORERS' HEALTH FUND
Feel the Power

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-842-9101

Consent for Deductible Waiver under the Wellness Program

By signing below, you acknowledge that you are not accepting the Gift Card during the Wellness Year period of 1/1/24 – 12/31/24 and instead are choosing to have your deductible waived under the Health Plan for the Calendar Year 2025. Please note that if married, both the member and spouse must agree and sign to have their deductible waived rather than accept the gift card.

Please check:

Member: ☐
Spouse: ☐

Member SSN: _____

_____
Member's Name (Print)

_____ _____
Member's Signature Date

_____
Spouse's Name (Print)

_____ _____
Spouse's Signature Date

This form ***MUST*** be returned to the Health Fund for processing.

Your Options:

Email it to: wlclaims@benesys.com

Fax to: 608-846-3224
Mail to: WI Laborers Health Fund, 4633 Liuna Way, Suite 201, Deforest WI 53532

Important Instructions

Use this form when participating in the Wellness Program outside of an on-site scheduled Biometric Screening such as your Primary Care Physician (PCP).

It is REQUIRED to complete the first page of the Health Screening Program Consent and Authorization form, which includes one signature. The next two pages of the Health Risk Questionnaire is optional. However, it is preferred that you complete the Questionnaire as well.

Provide your portion of the completed required forms and the Primary Care Physician (PCP) form to your physician at the time of your office visit. Your physician will need to complete the PCP form and provide **ALL** your biometrics indicated on the form. **ALL required** forms must be faxed together to CMS. You will find CMS' contact information on the bottom of the PCP form.

Please keep in mind, it is your responsibility to provide ALL forms to CMS for processing. You should request a copy of the completed form from your physician to keep for your records. If within one month of your doctor's visit, you do not receive in the mail your CMS Health Report, please contact CMS at 262-563-6460. Begin by providing specific information, including the name of the Health Fund, your name, and the date of your office visit or when the forms were faxed.

Thank you

Health Survey Questionnaire

This voluntary health questionnaire and screening program is utilized to gather sufficient wellness information, so you can receive an individualized and confidential report.

Employer Group: **Wisconsin Laborers**

Print Name:_____ **Date of Birth:**_____
Mailing Address: _____**City:**_____ **State:** _____ **Zip:**_____
Best Contact Phone Number: _____**Email address:**_____
Gender: □ **Male** □ **Female**
I am the: □ **Employee** □ **Spouse of employee**
Assessment Date:_____
Assessment Setting: □ **Screening Event** □ **Doctor's Office** □ **Telephone** □ **Onsite Clinic**

Consent and Authorization to Release Information

I hereby agree to participate in this voluntary health assessment and/or screening offered by the employer noted above and conducted by CMS, Inc. and/or its subcontractors and program partners. I understand this health assessment/screening, and any other additional programming, consultation or follow-up is not a substitute for a full examination provided by my own physician. I understand I am responsible to schedule any appropriate follow up examinations with my physician. Health coaching or condition care management that may be included or offered to participants as part of this program are a support system utilizing educational based approaches and planning to improve participant health. All information and education provided by health coaches or condition care managers are suggestions and should be cleared with a medical doctor before implementing. I understand that there are possible risks associated with venipuncture or fingerstick methods including but not limited to risk of infection, discomfort, bruising, minor bleeding and in unusual situations, more serious risks (including death). I agree that CMS, Inc. its subcontractors and/or partners are not liable for such risks when acting properly, and that I will assume the risk of injuries, including death, damages or loss, which I may sustain as a result of my participation in this assessment. I consent to the taking of blood from me by a qualified examiner. I understand that I may refuse to sign this Consent, but if I do so, I will not be processed as a participant in the health assessment/screening program, and therefore may be subject to employer plan penalties, or forfeit employer plan incentives. I understand that CMS, Inc., and its vendors, contractors and partners are required by law to maintain the confidentiality of the medical information that I provide through this assessment. The medical information includes my biometric results and other information about the manifestation of a disease or disorder that CMS, Inc. uses to provide wellness services and/or reports to me and/or my spouse. CMS, Inc. abides by and follows all HIPAA privacy laws and is restricted in how my or my spouse's medical information can be used or disclosed. I hereby provide my voluntary consent to participate.

Authorization to Release Information:

I hereby authorize CMS, Inc. and/or its subcontractors or partners to release my name as a participant, my participant status, and other limited health "information" to above employer for the purposes of administering the wellness program. I authorize CMS, Inc. to release information to above employer, and any other engaged vendor, including CMS, Inc., that may provide follow up coaching, care management, education or related services, as well as administration of employer incentives if applicable. All other health information from this assessment is to be considered confidential, and not shared with the above employer. I hereby understand the following:

- Above employer may condition my enrollment in a health plan or eligibility for benefits upon my executing this Authorization.
- This Authorization is effective until the earlier of: (1) the date is revoked or superseded; or (2) one year after the date I signed it.
- I may revoke this Authorization at any time in writing provided to CMS, Inc. Attn: Privacy Officer, PO Box 102 Nashotah, WI 53058. My revocation will not be effective until received by CMs, Inc. and will not be effective: (1) regarding any disclosure that CMS, Inc. made prior to receipt of my revocation; or (2) if this Authorization was obtained as a condition of obtaining insurance coverage.
- I have the right to request access to health information I have authorized to be used or disclosed pursuant to this Authorization. I may arrange to obtain copies of my health information by contacting CMS, Inc.'s Privacy Officer @ 1-800-861-8750.
- Information disclosed pursuant to this Authorization may be subject to redisclosure and no longer protected by federal privacy standards.
- A photocopy will be as valid as the original.
- If a disclosure is required by law, CMS, Inc. or its representative may be required to make the disclosure.
- I may request a copy of this Authorization
- I may refuse to sign this Authorization, but if I do so, I will not be processed as a participant in the health assessment/screening program.

Signature (required):_____ **Date:**_____

DEMOGRAPHICS

1. Gender at birth: □ Male □ Female
2. Current Age: _____
3. Race: □ White/Caucasian □ Black or African American □ Hispanic □ Asian □ American Indian/Alaska Native □ Other
4. Marital Status: □ Single □ Married □ Divorced □ Domestic Partner □ Separated □ Widowed □ Other
5. Education Level: □ High School or less □ High School Graduate/GED □ Some College □ College Graduate
6. □ Post-Graduate or Professional Degree
7. If female, are you pregnant? □ Yes □ No □ Unsure If yes, what is your expected due date:_____

PERSONAL HEALTH HISTORY

1. What is your personal history with the following health conditions?

	None	Had in past	Have currently	On medication for	Receiving medical care for
Asthma/Allergies	□	□	□	□	□
Arthritis	□	□	□	□	□
Back Pain/Chronic Pain	□	□	□	□	□
Cancer	□	□	□	□	□
Chronic bronchitis/emphysema/COPD	□	□	□	□	□
Depression/Other mental health condition	□	□	□	□	□
Diabetes	□	□	□	□	□
Heart Disease/Heart Failure	□	□	□	□	□
Heartburn/acid reflux/GERD	□	□	□	□	□
High blood pressure	□	□	□	□	□
High cholesterol	□	□	□	□	□
Kidney Disease	□	□	□	□	□
Liver Disease	□	□	□	□	□
Migraine headaches	□	□	□	□	□
Overweight/obesity	□	□	□	□	□
Sleep disorder	□	□	□	□	□
Thyroid disease	□	□	□	□	□
Other condition	□	□	□	□	□

2. Do you currently need or use medicine prescribed by a doctor (other than vitamins) for ANY medical, behavioral or other health condition? □ Yes □ No Do you feel your medications are effective in managing your health conditions? □ Yes □ No
3. Do you see a specialist for any of your conditions? □ Yes □ No
4. How many inpatient stays in the hospital have you had in the past 12 months? □ 0 □ 1 □ 2 □ more than 2
5. How many emergency rooms visits have you had in the last 6 months? □ 0 □ 1 □ 2 □ more than

GENERAL HEALTH

1. Considering your age, how would you describe your overall health? □ Excellent □ Very good □ Good □ Fair □ Poor
2. Do you have any concerns about your health or physical well-being? □ Yes □ No □ Unsure
3. **If Female:**
   How often do you examine your breasts for lumps? □ Monthly □ Once every few months □ Rarely or never
4. **If Male:**
   How often do you examine your testicles for lumps? □ Monthly □ Once every few months □ Rarely or never
5. When in the sun, do you protect your skin by using a sunscreen at SPF 15 or above and by wearing protective clothing such as a hat and long sleeves? □ All of the time □ Most of the time □ Some of the time □ Rarely or never
6. How many hours of sleep do you usually get a day? □ 5 hours or less □ 6 hours □ 7 hours □ 8 hours □ 9 or more hours
7. How would you describe your physical activity/exercise level? □ None □ Low □ Moderate □ High
8. In an average week, how many times do you exercise for 20 minutes without stopping? □ None □ 1 to 2 □ 3 to 4 □ 5 or more

NUTRITION

1. How often do you eat foods high in fat or cholesterol? (chips, fast food, fried foods, whole milk, ice cream)
   □ Rarely or never □ Occasionally □ 1 to 2 times per day □ 3 to 4 times per day □ 5 or more times per day
2. How often do you drink high sugar drinks such as non diet soda, Kool-Aid or sweetened juice?
   □ Rarely or never □ Occasionally □ 1 to 2 times per day □ 3 to 4 times per day □ 5 or more times per day
3. Do you drink more than 24 ounces a day of soda, caffeinated beverages or energy drinks? □ Yes □ No
4. How often do you drink caffeinated beverages?
   □ Rarely or never □ Occasionally □ 1 to 2 times per day □ 3 to 4 times per day □ 5 or more times per day
5. How many servings of fruits and vegetables do you eat a day? (1 serving = about one-half cup. 1 serving of greens = 1 full cup. A single piece of fruit, such as an apple or an orange = 1 serving.)
   □ 0 □ 1 □ 2 □ 3 □ 4 □ 5
6. How many servings of dairy products do you eat a day? (1 cup = 1 serving. 1 ½ cup to 2 ozs. of cheese = 1 serving)
   □ 0 □ 1 □ 2 □ 3 □ 4 □ 5
7. How often do you eat foods high in fiber? (fruits, vegetables, whole grain bread)
   □ Rarely or never □ Occasionally □ 1 to 2 times per day □ 3 to 4 times per day □ 5 or more times per day

TOBACCO/AICOHOL/SUBSTANCES

1. Which best describes your use of tobacco products?
   □ Never used □ Current user trying to quit □ Current user not trying to quit □ Previous user
2. If current user trying to quit OR current user not trying to quit, please answer the next 3 questions.
   a. Type(s) used? □ Cigarettes □ Cigars □ Chewing Tobacco □ Pipe □ Snuff □ E-Cigarettes
   b. Number of years used? _____
   c. Average number of times per day?_____
3. If you quit, how long since you used tobacco?_____
4. Are you exposed to second-hand smoke at home or work? □ Yes □ No
5. How many drinks of alcohol do you have in a typical week? (A drink = 12 oz. beer, a 5 oz. glass of wine, a shot of whiskey)
   □ None □ 1 to 7 □ 8 to 14 □ More than 14
6. Do you have any substance abuse concerns? □ Yes □ No □ Unsure

STRESS MANAGEMENT

1. How often do you feel tense, anxious or depressed? □ Often □ Sometimes □ Rarely □ Never
2. How would you describe your ability to manage stress in your life?
   □ Can't seem to manage □ Some difficulty managing □ Manage reasonably well □ Excellent management skills
3. During the past year, how much has stress affected your health? □ A lot □ Some □ Not much □ None
4. Have you experience a significantly stressful life event in the last year? (i.e.: a job loss, divorce, change in financial state, a move, a new disability, jail term, or a death) □ Yes, two or more serious losses □ Yes, one serious loss □ No
5. In general, how satisfied are you with your life? □ Very satisfied □ Mostly satisfied □ Partly satisfied □ Not satisfied
6. In general, how strong are your social ties with your family and/or friends? □ Very strong □ Average □ Weak □ Non-existent
7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities? (like visiting with friends, relatives, etc.) □ Never □ Occasionally □ Most of the time

GOALS

In the next 6 months, do you plan to make any of the following changes to keep yourself healthy or improve your health?

HEALTH	**No**	**Considering uncertain**	**Committed to change**	**Currently working on**	**Not needed**
Increase Physical activity	□	□	□	□	□
Lose weight	□	□	□	□	□
Reduce alcohol use	□	□	□	□	□
Quit or cut smoking	□	□	□	□	□
Reduce fat/cholesterol intake/lower cholesterol level	□	□	□	□	□
Lower blood pressure	□	□	□	□	□
Cope better with stress	□	□	□	□	□

Improve blood sugar control	☐	☐	☐	☐	☐
Get more hours of sleep per day	☐	☐	☐	☐	☐
Take medications as ordered	☐	☐	☐	☐	☐
Participate in a program focused on improving overall health	☐	☐	☐	☐	☐

PREVENTATIVE

When was the last time you had these preventative services or health screenings?

	Within last year	1–2 yrs ago	2-3 yrs ago	3-4 yrs ago	5 yrs ago	6+ yrs ago	Unsure	Never
Colon cancer screen (such as colonoscopy, sigmoidoscopy, rectal exam)	☐	☐	☐	☐	☐	☐	☐	☐
Flu Shot/Pneumonia Shot	☐	☐	☐	☐	☐	☐	☐	☐
Tetanus shot	☐	☐	☐	☐	☐	☐	☐	☐
Dental exam	☐	☐	☐	☐	☐	☐	☐	☐
Routine eye exam/diabetic retinal exam	☐	☐	☐	☐	☐	☐	☐	☐
Routine physical exam	☐	☐	☐	☐	☐	☐	☐	☐
If female, fill in the next three questions								
Cervical cancer screening (pap test)	☐	☐	☐	☐	☐	☐	☐	☐
Mammogram	☐	☐	☐	☐	☐	☐	☐	☐
Breast exam by health care professional	☐	☐	☐	☐	☐	☐	☐	☐
If male, fill in the next 2 questions								
Prostate exam	☐	☐	☐	☐	☐	☐	☐	☐
Prostate cancer screening (PSA)	☐	☐	☐	☐	☐	☐	☐	☐

SAFETY

1. How worried are you about your own safety or the safety of your family? ☐ Very worried ☐ Somewhat worried ☐ Not worried
2. Are you exposed to physical or emotional abuse? ☐ Yes ☐ No
3. Have you had any significant fall with injuries in the last 6 months? ☐ Yes ☐ No
4. How often do you use a seat belt when riding in a motor vehicle? ☐ Always ☐ Sometimes ☐ Never
5. On average, how close to the speed limit do you usually drive?
   ☐ Within 5 mph of the speed limit ☐ 6-10 mph over the limit ☐ More than 10 mph over the limit

EMPLOYMENT

1. Current work status: ☐ Full Time ☐ Part-time ☐ Unemployed
2. Would you agree you are satisfied with your job? ☐ Agree strongly ☐ Agree ☐ Disagree ☐ Disagree strongly
3. In the past 4 weeks, how often did you come in early to work, go home late or work on your day off?
   ☐ Not at all ☐ Infrequently ☐ Several days ☐ Almost everyday
4. Compared to others doing your job, how would you rate your productivity/job performance?
   ☐ Above average ☐ Average ☐ Below average
5. During the past 4 weeks, how much did your health problems affect your productivity while you were working?
   ☐ No health problems ☐ None of the time ☐ Some of the time ☐ Most of the time ☐ All of the time
6. How many days of work have you missed in the last 4 weeks due to your own physical or mental health problems?
   ☐ 0 ☐ 1-2 days ☐ 3-5 days ☐ 6-10 days ☐ 11-15 days ☐ 16 days or more
7. How many hours did you take off from work over the past 2 weeks to take care of others? (For instance taking care of sick children, taking others to doctor's appointments, staying home with an ill parent.)
   ☐ 0 ☐ 1-4 hours ☐ 5-8 hours ☐ 9-16 hours ☐ 17 or more hours

BIOMETRIC MEASUREMENTS

To be completed by a health examiner, or attach a separate physician completed form or test results.

Primary Care Provider (PCP) Form - Biometric Screening

Wisconsin Laborers Health Fund: is authorizing your patient to have their biometric screening completed at your office with payment through their own insurance.

The following information is needed to meet the requirements of participation in the screening:

Date of Biometric Screening: _____

Participant Information and Biometrics (to be completed by PCP/Participant)

Name	
Date of Birth	
Best Contact Number	
Height	
Weight	
Blood Pressure	
Inches around waist at belly button to nearest ¼"	
BMI	
Body Fat %	
Participant uses nicotine Products: (Yes or No)	

Blood Tests (to be completed by PCP - provide result for ALL tests listed)

Total Cholesterol	
LDL Cholesterol	
HDL Cholesterol	
Chol/HDL Ratio	
Triglycerides	
Glucose	
A1c	

PRIMARY CARE PROVIDER (PCP) - contact Case Management Specialists, Inc. at the number listed below if you have any questions regarding the blood test requirements.

_____ _____

PCP Name (Printed) **PCP Signature and Date**

PARTICIPANT - mail this form along with the health assessment questionnaire to:

Case Management Specialists, Inc., ATTN: HRA Processing Dept
PO Box 102
Nashotah, WI 53058 **OR** FAX to 262-369-7970

Contact Case Management Specialists, Inc. with questions at 262-563-6460

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CASE MANAGEMENT SPECIALISTS, INC.

Wisconsin Laborers Lab Test Reference Ranges

TEST	Very Good	Good	Fair	Poor	Union Guidelines for Pass/Fail
Nicotine (Lab)*	Neg	Neg	Neg	Pos	Only **Local 400** has nicotine + penalty
Self reported	No/quit	No/quit	No/quit	Yes	
Body Weight/Mass	18.5 - 24.9	25 - 29.9	30 - 34.9	35+	</= 27.5
OR (whichever is better)					
BF% (Men)	<24.9	24.9 - 29.9	30.0 - 40.0	39.9 and higher	</= 24.9
(Women)	<35.9	35.9 - 39.9	40.0 - 45.0	44.9 and higher	</= 35.9
Blood Pressure** (Systolic)	120 or less	121-129	130-139 or	140+ or	</= 140
(Diastolic)	80 or less	80 or less	80-89	90+	</= 90
Glucose (Non Fasting)***	<100 mg/dl	100-150 mg/dl	151-199 mg/dl	>200 mg/dl	</=200
A1c	< 5.6	5.7	5.8-6.4	6.5 or higher	
Triglycerides	<150	151-174	175-199	200+	
LDL	<100	101-129	130-159	160+	
HDL (Men)	50 or higher	45-49	40-44	39 or lower	
(Women)	60 or higher	50-59	40-49	39 or lower	
Total Cholesterol	<200	200-219	220-239	240+	< 200
Total Chol/HDL Ratio (Men)	3.4 or lower	3.5-5.0	5.1-9.5	9.6 or higher	</= 5.0
(Women)	3.3 or lower	3.4-4.4	4.5-7.1	7.2 or higher	</= 4.4

*****If you meet the acceptable biometric ranges, you are NOT required to do any coaching sessions.**

If you DID NOT meet the Fund's acceptable biometric ranges, you may participate in health coaching. If you participate and complete 2-4 health coaching sessions, you would be entitled to a one-time $100 Health Reimbursement Account (HRA) credit.

The $100 credit will be posted to your HRA after the Health Fund receives confirmation that you have completed your coaching. (NOTE: the HRA credit does not apply to Early Retirees).

Health coaching is available to all risk levels; maximum limit of four sessions.

(Continued on next page)

All telephonic coaching for this period must begin no later than January 31, 2025, as the coaching must be completed no later than March 31, 2025. It is your responsibility to plan your coaching sessions ahead of the completion date.

Remember that health and wellness changes are behaviors that occur over time. To achieve the best overall results, take advantage of your health coaching. Not rushing through health and wellness has been shown to be a good recipe for success!

If you have significant concerns regarding your health, or one to two months have passed and you have not heard from a Health Coach, please contact CMS at 262-563-6460. All coaching sessions must begin no later than January 31, 2025.

**References:

3. ABIM 2021 guidelines per Merck Manual
https://www.merckmanuals.com/professional/resources/normal-laboratory-values/blood-tests-normal-values