Welcome to the TriHealth Healthy Directions Wellness Program!

Dear Central State University Employee:

Central State University is promoting wellness services for all benefits-eligible employees. To get the new wellness program off to an exciting start, you will receive a 30% premium discount on your Central State University monthly healthcare premium beginning 11/01/2015 after doing the following:

- Complete and sign the Registration Form
- Complete and sign the Tobacco Affidavit
  - If you use tobacco, you will be eligible to receive the discount on your healthcare premium if you complete the TC 123 tobacco cessation program by 11/1/2015.
- Complete your health risk assessment, found at www.myuhc.com. Earn $75 in gift cards for completion.
- Schedule an annual preventive physical with your doctor
  - Your physical must occur between 11/2/2014 and 11/1/2015.
  - NOTE: If you have already had your annual preventive physical between 11/2/2014 and 11/1/2015, return to your doctor with the TriHealth packet and have the office staff complete the Biometric Measures and Physical Confirmation Form.
  - If you do not have a doctor – You can select a doctor that is in the UHC health benefit plan network. If you need assistance in finding a physician please go to www.myuhc.com.
- Take the TriHealth packet with you to your doctor appointment.
- Have your doctor complete the Biometric Measures and Physical Confirmation Form
- Submit your completed packet at one time by 11/1/2015:
  - Scan and email to healthydirectionspcp@trihealth.com
  - Secure fax 513 852 3166
  - Mail to Healthy Directions, 11129 Kenwood Road, Cincinnati, OH 45242

Please keep a copy of all forms for your files.
We will notify you when your packet has been processed. Allow 7-10 business days for that to occur.

Questions about the process?
Please contact us at healthydirectionspcp@trihealth.com or at 513 977 2170.
Wellness Program Registration Form

PLEASE PRINT CLEARLY

Employer: Central State University – Union CSUSA

First Name: ___________________________ Last Name: ___________________________

Date of Birth: _ _/ _/ _ _ _ _ Select One: ☐ Male ☐ Female

Home Address: ___________________________ City: ____________ ST: _____ Zip Code: ______

Daytime Phone: _____-____-_______ Email: ____________________________

My participation in TriHealth Healthy Directions program is voluntary. I understand that the responsibility for initiating a follow-up examination to confirm results of any physical screening and obtain professional medical assistance is mine alone, and not that of my health plan, employer or Bethesda Healthcare, Inc. /TriHealth, Inc. Bethesda Healthcare, Inc. /TriHealth, Inc. will disclose to my employer that I had a physical, underwent laboratory testing, and that I completed a tobacco affidavit. Bethesda Healthcare, Inc. /TriHealth, Inc. will make this disclosure in order for my employer to determine my eligibility for medical insurance premium discounts. My employer will not have access to any of my specific medical information provided under the Healthy Directions Program.

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 plans/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, USI Insurance Services LLC and USI Holdings Corporation (“USI”). 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 and tobacco affidavit by Bethesda Healthcare Inc. /TriHealth, Inc. 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 affirm that I have read, understand and agree to the terms set forth above and I wish to participate in Healthy Directions Program on the terms specified.

________________________________________________________  ____________________________
*Signature of Participant (REQUIRED) *Signature of Participant (REQUIRED)

___________________  ________________
*Date *Date

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TriHealthCorporateHealth.com | 513 891 1622
Tobacco Affidavit

To encourage overall good health, Central State University employees are encouraged to certify that they are tobacco-free OR complete the TC 123 program (the reasonable alternative standard) as part of qualifying for the discount on Central State University healthcare premiums. Please read this document carefully for more details.

Eligibility

You are considered a non-tobacco user if:

- You are currently not using tobacco products (including cigarettes, cigars, and chewing tobacco), or
- You use tobacco products but have complete TC 123 program (the reasonable alternative standard).

You will not qualify as a non-tobacco user if you are currently using any form of tobacco (including cigarettes, cigars, and chewing tobacco) in any amount (including occasional social use) and choose not to participate in TC 123 program as the reasonable alternative standard.

Documentation

- If you do not complete and submit this form, you will be ineligible for the non-tobacco user discount, regardless of your tobacco use.
- You must update your tobacco use status at each annual open enrollment period in order to qualify for the non-tobacco user discount.
- Providing false information on this form will subject the employee to immediate revocation of the discount and can subject the employee to disciplinary action up to and including termination of employment.
- Central State University has the right to request documentation at any time from an employee (or, as to the employee, from the vendor) when the employee declares him/herself a tobacco user enrolled in a tobacco cessation program for the sole purpose of verifying enrollment or activity. An employee who is unable to provide proof of participation in an approved program is subject to immediate revocation of the discount.

Alternative Reasonable Standard

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact your Wellness Coordinator, Molly Cropenbaker (513-977-0027) and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Certification (to be completed by the participant)

I hereby certify that I understand the above information and am a: (place an ‘X’ before appropriate statement)

- [ ] non-tobacco user
- [ ] tobacco user
- [ ] tobacco user completed TC 123 program.

______________________________________________
Signature

______________________________________________
Date

______________________________________________
Printed Name

______________________________________________
Date of Birth
Welcome to the TC 123 Program!

In order to qualify for a discount on medical premiums, the Central State University employee who uses tobacco needs to complete the CONCERN Services TC 123 Tobacco Cessation Program by 11/1/2015.

Program Description
The CONCERN Services TC 123 Program is a Cessation Readiness Program. Its goal is to give you the education and tools to make a healthy, individualized decision about your tobacco use.

The Program
To complete the program you will need to:
1. Participate in a telephone coaching session with a CONCERN coach
2. Watch three webinars on smoking cessation, found on CONCERN’s website
3. Take and pass the three post-tests that accompany each webinar
4. Fill out the handout: “Your Own Plan to Quit,” formulating a specific plan on how they would quit tobacco
5. Participate in a second coaching session with a CONCERN coach, to review the handout

Program Completion
Once you complete the final coaching session, your completion will be reported to Healthy Directions.

Getting Started
To get started with the TC 123 Program, please call 1 800 642 9794 to schedule your first coaching session.

In order to receive credit for the TC 123 Smoking Cessation Program, you must start the program no later than 10/1/2015. You will not be able to start the TC123 Smoking Cessation program if you should call after this date.

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Participant Name: ____________________________ Date of Birth: ____________________
Employer Name: Central State University - CSUSA

- The primary care physician needs to complete all information with an * in front of it.
- All testing must have been completed between 11/2/2014 and 11/1/2015.

<table>
<thead>
<tr>
<th>Biometric Measures</th>
<th>Value</th>
<th>Test Date (Month/Day/Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Total Cholesterol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Triglyceride Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Glucose (fasting)</td>
<td></td>
<td></td>
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<tr>
<td>*HDL Cholesterol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*LDL Cholesterol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemoglobin A1c (if physician recommended)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Systolic Blood Pressure</td>
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<td></td>
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<tr>
<td>*Diastolic Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Height (in feet, inches)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Weight (in pounds)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Abdominal Circumference (in inches)</td>
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</tr>
</tbody>
</table>

- *Does your patient have a history of coronary artery disease (MI, CABG, PTCA)?   _____yes _____no
- *Does your patient have a history of diabetes?                                      _____yes _____no
- *If no, does your patient have pre-diabetes?                                         _____yes _____no
- *Does your patient exercise weekly? If so, how often?  ________ days/week  ________ minutes/day

<table>
<thead>
<tr>
<th>Physical Confirmation</th>
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</thead>
<tbody>
<tr>
<td>Type of Service Provided</td>
<td></td>
<td></td>
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<tr>
<td>Complete Annual Preventive Physical</td>
<td></td>
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</tr>
</tbody>
</table>

*Signature of health care provider

*Date of Service

_______/_______/_______

*Date

Submit completed packet:

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