Catholic Diocese Cleveland

ANNUAL PHYSICAL AND TOBACCO ATTESTATION FORM

INSTRUCTIONS FOR HEALTH CARE PARTICIPANTS

The Catholic Diocese of Cleveland is committed to helping you and your family achieve your best health! Part of good health is completing age and gender appropriate preventive care with a primary healthcare provider such as a family doctor. Your doctor or provider will tell you what types of preventative care may be appropriate for you.

Your health is important to us all. The Diocese will reduce the cost of your health care premium payments if you visit a physician and complete your preventive care exam between the dates of May 1, 2024 and April 30, 2025.*

IMPORTANT NOTE REGARDING BLOODWORK: The preventative exam and the wellness tests, such as blood pressure, cholesterol levels, and fasting blood sugar levels are covered at 100%. If you are covered under the MMO PPO/HSA Plan or the MMO PPO Plan, you would need to go to a lab that has agreed to the Maximum Allowable Cost in order for the wellness tests to be covered at 100%. Other tests your physician may recommend may not be covered at 100%, such as testing for vitamin D levels and testing for thyroid abnormalities. To confirm level of coverage for optional tests, you can contact Medical Mutual of Ohio (800) 610-2583 before undergoing such tests. You can also log into your My Health Plan account at member.medmutual.com and click, "Find a Provider & Cost Estimates" to compare costs between doctors and medical service providers. One annual physical is covered per calendar year, January through December, not 12 months from the date of your last physical.

The Diocese will also reduce the cost of your health care premium payments if you do not use nicotine/tobacco products and attest to that by April 30, 2025. You can also receive the reduced health care premium by enrolling in Medical Mutual's Pivot Breathe nicotine/tobacco cessation program by May 1, 2025.*

*Participants must be enrolled in a Diocesan Medical Plan (non-Medicare primary) in order to receive an incentive.

IMPORTANT – Both you and your covered spouse must fully complete and submit SEPARATE forms to achieve the incentive if you have family medical coverage.

What is the incentive?

- Preventative Physical Incentive:
 - Single Coverage: \$15 reduction in monthly premium payments, totaling \$180 annual premium reduction
 - Family Coverage: \$30 reduction in monthly premium payments, totaling \$360 annual premium reduction
- Tobacco Free Incentive:
 - Single Coverage: \$15 reduction in monthly premium payments, totaling \$180 annual premium reduction
 - Family Coverage: \$30 reduction in monthly premium payments, totaling \$360 annual premium reduction

If you wish to participate in the Diocesan wellness incentive program, this Annual Physical and Tobacco Attestation Form needs to be completed by you and your primary care provider. Please review your form before submitting to ensure:

- your primary care provider completed, signed and dated the form
- you completed the Tobacco Statement
- you sign and date the form

You are responsible for the submission of the incentive form(s) to the Employee Benefits Office.

Return this form to the Diocesan Employee Benefits Office after your physical and NO LATER THAN May 1, 2025. YOU WILL NOT BE ELIGIBLE FOR THE INCENTIVE PREMIUM REDUCTION FOR THE 2025-2026 PLAN YEAR IF YOUR FORM IS NOT RECEIVED BY MAY 1, 2025 (NO EXCEPTIONS).

MAIL: Employee Benefits Office 1404 East Ninth Street, 8th Floor Cleveland, OH 44114 FAX: 216-621-9622

EMAIL: hbo@dioceseofcleveland.org

If you have questions, please call 216-696-6525 x 5040



ANNUAL PHYSICAL AND TOBACCO ATTESTATION FORM

Annual Physicals Must be Completed Between May 1, 2024 and April 30, 2025

articipant Name: Please print clearly):			Phone #:
ast 4 digits of Employee's SS#:	Employee	Spouse	Date of Birth:
mail:			
TO BE COMPLETED BY PHYSICIAN I hereby acknowledge that above participant completed	d a preventive care physical		
		Ph	ysician License #:
Date of Physical:			
You may record date of annual physical completed sinc One annual physical is covered per calendar year, Janua Provider/Physician: Once this form is	ary through December; not	12 months from t	the date of your last physical.
Provider Signature:			
Printed Name:			
Phone Number:			Date:
TO BE COMPLETED BY PARTICIPANT	(TOBACCO STATE	MENT)	Employee Spouse
Have you used tobacco/nicotine product	ts within the past 90	days?	YES NO
** I am interested in enrolling in Nicoti	ne/Tobacco Cessati	on:	_
Tobacco or nicotine usage includes, but is not lim nicotine patch, nicotine gum or other nicotine sup		arettes, cigars,	vaping, pipe smoking, snuff, chewing tobacco,
** Nicotine/Tobacco Cessation: If you a Diocese of Cleveland will award you with nicotine/ tobacco when you participate in Cessation Program by May 1, 2025. The	n the same premium in the Medical Mutu	reduction ir	ncentive as participants who do not use other program. You must enroll in the
pivot.co/medmutual.			
Participant			
Signature:			Date:

Return this form to the Diocesan Health Benefits Office after your physical and NO LATER THAN May 1, 2025

If you have questions, please call 216-696-6525 x5040

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Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information will be subject to criminal penalties applicable to state laws.