Your 2018 **Healthy Results** Biometric Scorecard

Michelin wants you and your family to enjoy everything that comes from being healthy, including lower medical expenses. That’s why we offer the **Healthy Results** incentive to you and your spouse or domestic partner: to reward each of you for managing your metabolic risk factors.

**Take the scorecard with you to your annual physical.** If you have had an annual physical on or after September 17, 2016 you can use those results; but your health care provider must complete all five required biometrics and sign the scorecard. **You** must submit the completed scorecard between February 1, 2017 and September 15, 2017 following the instructions below.

**What you need to do to earn the Healthy Results incentive**

1. Complete the Participant Information section of the scorecard and sign it. (Your covered spouse or domestic partner, if participating, must complete his or her own scorecard.)

<table>
<thead>
<tr>
<th>The Unique ID is as follows:</th>
<th>If Employee Chorus ID is 12345678:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>Chorus ID + S</td>
</tr>
<tr>
<td>Spouse or Domestic Partner</td>
<td>The employee’s Chorus ID + P (if the spouse/domestic partner is also a Michelin employee, it must be the policyholder’s Chorus ID + P)</td>
</tr>
</tbody>
</table>

2. **Be sure you fast** (have nothing to eat or drink except water for 9-12 hours) before your appointment. Drink plenty of water to avoid being dehydrated.

3. Have your health care provider complete the biometrics section and sign the bottom of the form, making sure all fields are completed. **Do not substitute other biometrics (weight or BMI instead of waist, A1C instead of glucose, etc.). If ANY of the five required biometrics are missing or this form is not submitted between February 1 and September 15, 2017, you will pay $75/month premium adjustment in 2018 and will not be eligible for 2018 incentives.** *If you are pregnant, contact your Benefits Advocate or visit www.choosewell-livewell.com for special instructions.*

4. **Submit** completed scorecard to HealthFitness Corporation **between February 1, 2017 and September 15, 2017.**

   **FAX:** 1-866-698-9924  **or**  **MAIL:** Health Fitness Corporation  
   18325 Waterview Parkway, Suite B200  
   Dallas, Texas 75252

   **UPLOAD:**  
   www.choosewell-livewell.com

   **IT IS THE MEMBER’S RESPONSIBILITY TO SUBMIT ALL FIVE BIOMETRICS WITHIN THE WINDOW. KEEP A COPY OF THE FAX OR UPLOAD CONFIRMATION AS PROOF OF SUBMISSION. DO NOT DEPEND ON YOUR HEALTH CARE PROVIDER TO SUBMIT THIS FORM.**

   The **first** value submitted for each biometric will be used to determine your incentives. Biometric values from additional submissions will only be used for a value missing on the first submission. **Your status will be updated on the CWLW Rewards page (www.choosewell-livewell.com then click Rewards) within 10 business days.**

5. **Complete the Personal Health Review between February 1, 2017 and September 15, 2017.** You can complete the PHR prior to your biometric results being entered. Simply enter your height and weight. The other biometric values will be populated with your biometric scorecard values or biometric screening results. **If you do not complete the PHR between February 1 and September 15, 2017, you will pay $75/month premium adjustment in 2018 and will not be eligible for 2018 incentives.**

6. By submitting all five certified biometrics in the table above and completing your PHR between February 1, 2017 and September 15, 2017, you will avoid the 2018 premium adjustment and be eligible to earn the Healthy Results incentive for 2018 based on your biometrics.

7. Your biometrics will be used to determine your 2017 Healthy Progress incentive (if applicable) and all of your 2018 Incentives. If you and your health care provider agree that your 2017 Healthy Progress target or your 2018 Healthy Results goal (including new improvement target) is not appropriate for you, contact your Benefits Advocate.

If you need assistance submitting this form, contact your Benefits Advocate.

1-9-17
Authorization to Release Biometric Screening Information
2018 Annual Enrollment

IMPORTANT: You and your health care provider must complete this entire form.

Participant information, health care provider’s signature: values for waist circumference, HDL, triglycerides, glucose (not A1C) and blood pressure are all required for certified biometrics.

If ANY of the above items are missing or this form is not submitted between February 1 and September 15, 2017, you will pay $75/month premium adjustment in 2018 and will not be eligible for 2018 incentives.

The member must fax this completed form to HealthFitness Corporation at 866-698-9924 or upload at www.choosewell-livewell.com between February 1 and September 15, 2017.

Do NOT depend on your health care provider to submit this form.

If you do not ALSO complete the PHR on the CWLW website (www.choosewell-livewell.com) between February 1 and September 15, 2017, you will pay $75/month premium adjustment in 2018 and will not be eligible for 2018 incentives.

Your status on the CWLW Rewards page (www.choosewell-livewell.com) may take up to 10 business days to appear.

PARTICIPANT INFORMATION:

| Unique ID (see instructions): | Full Legal Name: |
| Date of Birth: | Gender: Male Female |
| Preferred Telephone Number: | Email Address: |

BY SUBMITTING THIS FORM TO HEALTHFITNESS (WHETHER OR NOT SIGNED BY YOU), YOU HEREBY CONSENT TO THE USE AND DISCLOSURE OF YOUR HEALTH INFORMATION AS DESCRIBED BELOW.

Use and Disclosure of Your Information:
HealthFitness treats personally identifiable health information as confidential. The information you provide to us on this form will be used to:

- Generate a personalized health report for you.
- Generate a summary report so that your employer can understand the overall health strengths and concerns of the group. Your individual responses cannot be identified in the summary report.
- Inform you about materials, programs and services that might be useful to you.

The information you provide may be disclosed to the following individuals or groups as appropriate (as determined at HealthFitness’ sole discretion):

- Authorized HealthFitness employees;
- Authorized individuals working for your employer or other third parties to the extent reasonably necessary for us to operate employer-sponsored programs in which you participate, provided the receiving party agrees to maintain the confidentiality of your information and information is used only for the purposes noted;
- Assigned contractors, their agents and successors whom we use to support our business in connection with any program sponsored by your employer in which you participate, provided the receiving party agrees to maintain the confidentiality of your information and information is used only for the purposes noted;
- Vendors, contractors and other third parties authorized to provide services and/or programs for your employer’s health management plan, provided the receiving party agrees to maintain the confidentiality of your information and information is used only for the purposes noted;
- Those involved with the sale, assignment or transfer of business to which the information you give is related, provided they sign appropriate confidentiality agreements that maintain the confidentiality of your information;
- Those with whom we are required to share your information by applicable law, court orders or government regulations; or
- Health care personnel for treatment purposes including, for example, emergency assistance personnel.

MEDICAL FACILITY INFORMATION:

I hereby authorize the medical facility listed below to release biometric assessment data to HealthFitness.

Facility Name: ____________ Telephone Number: ____________

Participant Signature: __________________________ Date: ____________

BIOMETRIC ASSESSMENT: MEDICAL HEALTH CARE PROVIDER MUST COMPLETE AND SIGN THE INFORMATION BELOW

Are you fasting? This means you have NOT had anything to eat or drink other than water in the last 9-12 hours. Note: You may participate if you are not fasting, but your measurements and incentives may be adversely affected. No Yes

Height in inches: ________ Weight in pounds: ________ Waist in inches: ________ Total Cholesterol: ________

(Measured 1” ABOVE naval)

HDL: ________ LDL: ________ Triglycerides: ________ Glucose: ________ A1C is NOT acceptable

Blood Pressure: ________

Medical Health Care Provider Name (Please Print): __________________________________________________________________________

Medical Health Care Provider Signature: __________________________ Date: ____________