CHA
Health Plan
www.clearhealthalliance.com/member

Healthy Behaviors

Dear Member:

Thank you for your interest in our Smoking Cessation (SMO) Healthy Behaviors Rewards Programs. You're getting this mailing because your case manager or doctor referred you, you referred yourself or you've found this on our website. Your health is important to us. We will support and reward you for taking steps to better your health through our programs.

There are three separate SMO programs you can join. Each program has different steps to follow to earn a reward. Read the program forms attached for details. You can enroll in one or more SMO programs if you like. It's your choice. When you're ready, just tell your case manager or doctor when you want to enroll in another SMO program.

When you complete each program, you will get a gift card reward!

Want to enroll? Send us your enrollment form. To enroll in another program later, send us this form again. Download a copy from our website, www.clearhealthalliance.com/member.

Then, follow these steps:

1. See your doctor and follow the plan for each program in which you've enrolled.
2. Fill out the form for each program in which you've enrolled.
3. Let us know you completed your program. Send the form to us in one of these ways:
   - **Mail:**
     CHA Healthy Behaviors Programs
     9250 W. Flagler St., Ste. 600
     Miami, FL 33174-3460
   - **Fax:** 1-855-329-5289
   - **Email:** HealthyBehaviors@simplyhealthcareplans.com
4. Get your reward!

Have questions or need help? Call us at 1-844-406-2398 (TTY 711) or email us at HealthyBehaviors@simplyhealthcareplans.com.

Enclosures: Enrollment form
SMO program forms
Nondiscrimination notice
Get help in another language

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Smoking Cessation Healthy Behaviors Rewards Programs
Enrollment Form

Please fill out and sign this form to enroll in one or more Smoking Cessation (SMO) Healthy Behaviors Rewards Programs. For each SMO program you want to enroll in, place a checkmark (✓) in the **Yes, I want to enroll!** table column below.

Yes, I want to enroll!	Program	Description	Gift card
	SMO 1	Visit your primary care provider (PCP), choose a quit smoking program and submit your attendance certificate.	$50
	SMO 2	Be tobacco-free for one month and submit your personal and PCP attestations.	$20
	SMO 3	Stay tobacco-free for three months and submit your personal and PCP attestations.	$20

Rewards may not be used for gambling, alcohol, tobacco or prescription drugs.

Please tell us how to contact you.

Member name: _____ Date of birth: _____

Member ID #: _____ Cellphone number: _____

Email address: _____

_____

Street address City State ZIP code

Primary parent/caregiver name (if applicable): _____

How would you like us to contact you? (Check all that apply. Contact your case manager to disenroll from these communications at any time.) ☐ Call ☐ Text ☐ Email

Sign your name _____ Date _____

Send us this signed form in one of these ways:

- Mail: CHA Healthy Behaviors Programs, 9250 W. Flagler St., Ste. 600, Miami, FL 33174-3460
- Fax: 1-855-329-5289
- Email: HealthyBehaviors@simplyhealthcareplans.com

Have questions or need help? Call us at 1-844-406-2398 (TTY 711) or email us at HealthyBehaviors@simplyhealthcareplans.com.

Congratulations for taking a step toward better health!

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Smoking Cessation Healthy Behaviors Rewards Program 1 Form

After you've enrolled in this program:

1. Visit your doctor for a support visit.
2. Choose and attend a quit-smoking program/support group.

   Tobacco-Free Florida
   - www.quitnow.net/florida
   - www.tobaccofreeflorida.com
   - www.tobaccofreeflorida.com/teens
   - Florida Quit Line: 1-877-U-CAN-NOW (1-877-822-6669) to talk to a Quit Coach®

   Area Health Education Center
   - AHEC I Quit face-to-face classes in the local communities: www.ahectobacco.com
   - Or call 1-87-QUIT-NOW-6 (1-877-848-6696)
3. Send your program attendance certificate to us by mail, fax or email (see #5 below).
4. Sign below. Ask your doctor to sign, too.

   Sign your name _____ Date _____

   Doctor's signature _____ Date _____
5. Send us this signed form in one of these ways:
   - Mail: CHA Healthy Behaviors Programs, 9250 W. Flagler St., Ste. 600, Miami, FL 33174-3460
   - Fax: 1-855-329-5289
   - Email: HealthyBehaviors@simplyhealthcareplans.com
6. **Get a reward certificate in the mail! You will use it to order your $50 gift card.** Rewards may not be used for gambling, alcohol, tobacco or prescription drugs.

Note: Once you're enrolled in this program, you must complete it within 12 months to earn the reward.

We want to stay in touch. Please tell us how to reach you.

Member name: _____ Date of birth: _____

Member ID #: _____ Cellphone number: _____

Email address: _____

_____

Street address City State ZIP code

Primary parent/caregiver name (if applicable): _____

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Healthy Behaviors

Smoking Cessation Healthy Behaviors Rewards Program 2 Form

After you've enrolled in this program:

1. Quit smoking, vaping and using tobacco for one month.
2. Attend a quit-smoking program/support group. (This is optional.)
3. Follow your care plan and remain tobacco-free for one month.
4. Sign below. Ask your doctor to sign, too.

   Sign your name _____ Date _____

   Doctor's signature _____ Date _____

5. Send us this signed form in one of these ways:
   - Mail: CHA Healthy Behaviors Programs, 9250 W. Flagler St., Ste. 600, Miami, FL 33174-3460
   - Fax: 1-855-329-5289
   - Email: HealthyBehaviors@simplyhealthcareplans.com
6. **Get a reward certificate in the mail! You will use it to order your $20 gift card.** Rewards may not be used for gambling, alcohol, tobacco or prescription drugs.

Note: Once you're enrolled in this program, you must complete it within 12 months to earn the reward.

We want to stay in touch. Please tell us how to reach you.

Member name: _____ Date of birth: _____

Member ID #: _____ Cellphone number: _____

Email address: _____

_____

Street address City State ZIP code

Primary parent/caregiver name (if applicable): _____

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Healthy Behaviors

Smoking Cessation Healthy Behaviors Rewards Program 3 Form

After you've enrolled in this program:

1. Quit smoking, vaping and using tobacco for three months.
2. Attend a quit-smoking program/support group. (This is optional.)
3. Follow your care plan and remain tobacco-free for three months.
4. Sign below. Ask your doctor to sign, too.

   Sign your name _____ Date _____

   Doctor's signature _____ Date _____

5. Send us this signed form in one of these ways:
   - Mail: CHA Healthy Behaviors Programs, 9250 W. Flagler St., Ste. 600, Miami, FL 33174-3460
   - Fax: 1-855-329-5289
   - Email: HealthyBehaviors@simplyhealthcareplans.com
6. **Get a reward certificate in the mail! You will use it to order your $20 gift card.** Rewards may not be used for gambling, alcohol, tobacco or prescription drugs.

Note: Once you're enrolled in this program, you must complete it within 12 months to earn the reward.

We want to stay in touch. Please tell us how to reach you.

Member name: _____ Date of birth: _____

Member ID #: _____ Cellphone number: _____

Email address: _____

_____

Street address City State ZIP code

Primary parent/caregiver name (if applicable): _____