CPSB Employee/Retiree WELLNESS PROGRAM
05/01/2023 – 04/30/2024

Eligibility requirements: (check one)

_____Full-Time CPSB employee, enrolled in CPSB Health Insurance Plan

_____Retiree, enrolled in CPSB Health Insurance Plan

Name: _____

Address: _____

Phone: _____ DOB: _____

Email: _____ Campus/Site: _____

Participants earning a total of **8 points** by completing any combination of the services listed below will receive a 5% discount off the employee/retiree (not dependent or spouse) portion of the health insurance premium for the following plan year. Points must be earned during the program year and all documentation must be submitted by April 30, 2024.

- ❖ Perform blood work at CPSB's Wellness Fair (+) or with primary care physician   3 pts
- ❖ Mammogram or Prostate Exam (#)   2 pts
- ❖ Colonoscopy (#)   2 pts
- ❖ Participate in **ANY** 5K fun run, walk, marathon, etc. (May only use once – Active & Retiree) 2 pts
  - o Submit your event registration confirmation to wellness@cpsb.org
- ❖ Take flu, shingles, or pneumonia shot (#)   1 pt each
- ❖ Participate in the scavenger hunt at the CPSB Wellness Fair (+)   1 pt
- ❖ Attend any of CHRISTUS/Ochsner health-related informational seminars (+)   1 pt each
- ❖ Annual wellness exam/physical (#)   1 pt
- ❖ Annual eye exam (#)   1 pt
- ❖ Annual dental check-up (#)   1 pt
- ❖ Solutions EAP workshop (+) Active employees only   1 pt

(+) Participant does NOT need to turn in documentation for these points.
(#) Physician completes CPSB Wellness Program Verification Form, or you may submit your EOB to wellness@cpsb.org.

I, the undersigned employee/retiree, hereby agree to enroll in the CPSB Preventative Care Incentive Program. This voluntary program is being offered as a benefit to full time employees and retirees who are currently enrolled in the CPSB Group Health Insurance Plan. To qualify for incentives, the participant must complete the requirements during the program year. The Risk Management Department will track point totals and requirements.

_____   _____
Print Employee/Retiree Name   Date of completion

_____   _____
Employee/Retiree Signature   Risk Management Approval