# Welcome to your 2026 Wellness Program!

Healthy staff, happy clients and cost savings is a winning proposition for all. To encourage personal health and wellbeing as a priority, Midwest Concrete Materials offers employees and their spouses the opportunity to qualify for the following reductions in their medical premiums as a wellness discount.

- $36 monthly / $432 Annual medical premium discount for employees who complete the program; and
- An additional $24 monthly / $288 Annual medical premium discount for spouses on the plan who complete the program.

Both employees and their spouses may qualify for these wellness discounts separately by completing Steps 1 and 2, below. *

**DEADLINES:**

- New employees in 2026:
  - If you become eligible for benefits on or before May 31, 2026, you/your spouse must complete Steps 1 and 2 by October 16, 2026, to receive the Wellness Discount for the following plan year.
  - If you become eligible for benefits on or after June 1, 2026, you will keep the Wellness Discount for the remainder of the plan year; no further action is required.
- Current employees: To qualify for the Wellness Discount for the **2027** plan year, you/your spouse must complete Steps 1 and 2 within the timeframes noted below.

**STEP 1: PREVENTIVE EXAM**

Complete an annual preventive physical exam with your primary care physician by October 16, 2026. Take the attached form to your appointment and have your doctor complete and sign it. It is the participant's responsibility to return the form to HR in the Manhattan, Topeka, or Lawrence Office by October 16, 2026.

*If you do not have a primary care physician, you can find a doctor within the Midwest Concrete Materials, Inc. health plan network by using the following link or scanning the QR code by opening the camera on a smartphone (hover over the image).*

**https://www.bcbsks.com/find-a-doctor**

**STEP 2: PROVIDE PROOF OF EXAM BY October 16, 2026**

Please provide the completed form or other proof of exam to Human Resources Department in one of the following ways:

1. Scan and email the attached form to hr@midwestconcretematerials.com
2. Fax a copy to 785-776-1147
3. Provide the paper original to HR in the Manhattan, Topeka, or Lawrence Office.

*You do not need to wait for your results to have the form completed and submit to HR.

*Employees who choose to participate in the wellness program will receive the Wellness Discount in 2026. Although you and your spouses are not required to participate, only those who do so will receive the Wellness Discount.

# Annual Preventive Exam Employee's Results Form

**INSTRUCTIONS FOR EMPLOYEE/PATIENT:**

Take this form with you to your scheduled Annual Preventive Exam to be completed by your primary care physician. **Please retain this copy of this Preventive Exam Form for your records. ***

| Screening | Results |
|---|---|
| Blood Pressure (systolic) | |
| Blood Pressure (Diastolic) | |
| Height | |
| Weight | |
| BMI (Body Mass Index) | |
| Pulse (Heart Rate) | |

| Screening | Results |
|---|---|
| Total Cholesterol | |
| Low Density Lipoprotein (LDL) | |
| High Density Lipoprotein (HDL) | |
| TC/HDL Ratio | |
| Triglycerides | |
| Glucose (fasting) | |

**Tip:** When scheduling be sure to mention this is a preventive exam, not a DOT physical.

* Fasting (no food) for 9 hours before your appointment is recommended. Please drink plenty of water. Continue to take any prescription medications. If you are diabetic, please consult your physician before fasting.

# Annual Preventive Exam Form

**INSTRUCTIONS FOR EMPLOYEE/PATIENT**

Take this form with you to your scheduled Annual Preventive Exam to be completed by your primary care physician. **It is the participant's responsibility to return the completed form to Human Resources by October 16, 2026.** Please retain a copy of this Preventive Exam Form for your records. *Please note, you do NOT need to wait for your results to have the form completed and submit to HR.

Patient Last Name: _____ First Name: _____

Phone: _____ Email: _____

Signature: _____ Date: _____

**INSTRUCTIONS FOR PHYSICIAN**

1. Please confirm the tests below were administered and return to the patient named above.
2. Please note that your signature should indicate only whether the specified test or screening was performed, **not** whether it was within a healthy range.
3. Intent is for this screening to be conducted as part of an **ACA Preventive Exam** at no charge to the employee.

| Screening |
|---|
| Blood Pressure (systolic) |
| Blood Pressure (Diastolic) |
| Height |
| Weight |
| BMI (Body Mass Index) |
| Pulse (Heart Rate) |

| Screening |
|---|
| Total Cholesterol |
| Low Density Lipoprotein (LDL) |
| High Density Lipoprotein (HDL) |
| TC/HDL Ratio |
| Triglycerides |
| Glucose (fasting) |

Physician's Office/Name: _____

Office Phone #/Address: _____

I certify that the patient listed above was seen for their Annual Preventive Exam on ___/___/____.

Physician's Signature: _____ Date Signed: _____