2026 Wellness Rewards Program - Kaiser

Orion Steel Group, LLC encourages employees to lead a healthy and active lifestyle, and as such you have an opportunity to earn $300 in the 2026 calendar year. To receive your reward you must complete these steps by October 30th:

1. Get your annual preventive care exam.
   This is covered at no cost through your medical insurance.
2. Get your annual biometric screening.
   This includes a full lipid profile with cholesterol, blood sugar, and blood pressure.
3. Have your provider complete the attached form.
   Provide the completed form to Human Resources as instructed.

Deadlines

Payment will be made in December 2026.

Note: You must be an active employee at the time of payment (partial or early payments will not be provided). You will not be eligible for the credit if the bloodwork (biometrics) completed does not include ALL of the following: Total Cholesterol, HDL, LDL, Triglycerides, and Glucose.

KAISER PARTICIPANT WELLNESS PROGRAM PARTICIPATION FORM

TO BE COMPLETED BY PARTICIPANT:

Participant Name: _____

Participant Address: _____

_____

Participant Date of Birth: _____

Particant Email: _____

By signing and submitting this form I agree that I am currently an Orion employee enrolled in the Kaiser Medical plan. I agree to present this completed form to my local Human Resources department by October 30, 2026, to be eligible for an annual wellness credit of $300.00 on my final paycheck in December. I understand that it is my responsibility to: 1) ensure that test results are omitted from this form 2) direct questions regarding testing to those administering the tests and 3) follow up with my physician to discuss the results of these tests. ***Test results are considered private and confidential health information that should not be shared with the company's Human Resources.***

_____

Participant Signature

TO BE COMPLETED BY MEDICAL PROVIDER ONLY:

I hereby attest that the above-named participant (patient) received the following services (please check all that apply):

☐ *Preventive health exam, performed on*_____
(date)

☐ *Bloodwork, performed on*_____ *which includes (please check all that apply):*
(date)

- ☐ *Total cholesterol*
- ☐ *HDL*
- ☐ *LDL*
- ☐ *Triglycerides*
- ☐ *Glucose*
- ☐ *Fasting 9-12 hours*
- ☐ *Blood pressure*

Facility Name_____

Facility Phone Required_____

Printed Name of Medical Provider_____

NPI Number_____

MEDICAL PROVIDER SIGNATURE _____

*Today's Date____/___/____

Please provide completed form to the participant.

Form must be received by Human Resources by 10-30-2026.