



Dear Crouse Health Employee Health Plan Member:

The Crouse mission is to provide the best in patient care and to promote community health — this includes the well-being of our own employees and their families. Employees enrolled in the Crouse Hospital or Crouse Medical Practice Health Plans on or before August 1, 2026 are invited to participate in this program and earn up to \$500 by completing program requirements.

Sincerely,

Seth Kronenberg, MD
Chief Executive Officer

PROGRAM REQUIREMENTS:

1. Ensure your required appointments are scheduled, see “Program Checklist & Tips” section of this packet.
2. Work with your Primary Care Provider (PCP) to complete and submit the enclosed form.

**Employees who enroll in the health plan between June 1 – August 1 will have until August 1 to complete Step 1*

Your form will be processed by the Population Health Coordinators and will only be used for the purpose of this program.

INCENTIVE LEVELS & REQUIREMENTS

Level	General Information	Incentive Details
1	Complete Annual PCP Visit, Up-to-date Lab & Screening Services <i>Spouses eligible to complete Level 1 (requires Crouse health plan enrollment)</i>	Employee: \$100 Spouse Bonus: \$50
2	<i>Must successfully complete Level 1 to be eligible for Level 2 incentives</i> FOUR Health Goals: Healthy Weight, Blood Pressure, Blood Sugar/A1c, and LDL TOBACCO FREE STATUS <i>Visit www.crouse.org/wellness for programs supporting Tobacco Free status, including a FREE program offered by Excellus.</i>	Each Health Goal: \$75 Tobacco Free Status: \$25 <i>\$25 bonus if all goals are met and tobacco free status achieved</i>

Employee must be employed by Crouse Health or Crouse Medical Practice when the incentive is paid in 2027.

If your PCP determines that any of the program requirements are not medically appropriate based on your specific situation (ex: serious illness), your PCP can submit an exemption request. The request should include confirmation that you are following your individualized plan of care.

Services required for this program are covered with little or no cost share, according to the Crouse Health Employee Health Plan. Contact Excellus directly using the number on your health plan ID card for coverage questions.

Crouse Health is offering this program to support you and your relationship with your PCP. If you have any questions about this program or need a PCP, please email the Crouse Population Health Coordinators at

DLhealthincentiveprogram@crouse.org.

Program Tips & Checklist

MAKE YOUR APPOINTMENTS NOW!

- Use the below checklist to plan for your appointments (requirement details on program form).
- **Call your providers now** to set your appointments for the year. If you wait until the second half of the year to call, providers may not have available appointments to meet program deadlines.

HEALTH PLAN COVERAGE FOR SERVICES – CALENDAR YEAR COVERAGE

Crouse Health Plans offer “calendar year” coverage, meaning you do not need 365 days in between visits. For example, last year’s annual PCP visit on Dec. 1 → this year’s visit can be anytime, does not need to be on or after Dec. 2. Remind your provider(s) about the “calendar year” coverage (as needed).

Requirement	Guidance	Status/Appt Date:
Primary Care Visit <i>Calendar Year Coverage</i>	Need a PCP? Visit www.crouse.org/providers You are not required to have a Crouse PCP for this program.	____/____/____ <input type="checkbox"/> COMPLETED
Labwork	Fasting Cholesterol & Glucose A1c (Diabetics Only)	____/____/____ <input type="checkbox"/> COMPLETED
Breast Cancer Screening <i>Calendar Year Coverage</i>	Breast Centers may be scheduling 4-8 weeks out (or more) from the time you call to schedule.	____/____/____ <input type="checkbox"/> COMPLETED <input type="checkbox"/> DOES NOT APPLY
Cervical Cancer Screening “Pap Smear” <i>Calendar Year Coverage</i>	Make sure this is completed on your form. Your PCP may not have this on file. Please complete this section prior to giving the form to your PCP.	____/____/____ <input type="checkbox"/> COMPLETED <input type="checkbox"/> DOES NOT APPLY
Colorectal Cancer Screening <i>Various Coverage</i>	BEGINS AT AGE 45 Complete either colonoscopy or stool sample test. Colonoscopy: Specialists will typically schedule an initial appointment and then schedule the procedure. This process can take up to 3-5 months (or more) to complete. Call your PCP now to initiate process and discuss best option for you.	____/____/____ <input type="checkbox"/> COMPLETED <input type="checkbox"/> DOES NOT APPLY
Diabetic Eye Exam <i>Medical & Vision Plan Coverage</i>	Tell your eye care provider that you have diabetes so the appropriate exam is performed. Give your medical <u>and</u> vision insurance cards to your eye care provider. Request the exam report be sent to your PCP. Visit www.crouse.org/diabetes for more information.	____/____/____ <input type="checkbox"/> COMPLETED <input type="checkbox"/> DOES NOT APPLY
Spouse Bonus	Enrolled spouse can complete Level 1 for Bonus Incentive Obtain form at www.crouse.org/healthincentive <i>Employee must also complete Level 1 for spouse bonus to apply.</i> Note: Please be sure to attach spouse form to employee form to receive spouse incentive bonus.	<input type="checkbox"/> COMPLETED <input type="checkbox"/> DOES NOT APPLY
MEET DEADLINES	Services must be completed by December 31, 2026 FORM MUST BE SUBMITTED BY JANUARY 15, 2027 It is your responsibility to contact the Crouse Population Health Coordinators to ensure your form was received.	<input type="checkbox"/> COMPLETED

FAX FORM BY **JANUARY 15, 2027** to Program Coordinator at 315-470-2881 or e-mail at DLhealthincentiveprogram@crouse.org
It is your responsibility to contact the Crouse Population Health Coordinators to ensure your form was received.
 Visit Crouse.org/healthincentive to obtain additional copies of this form.

PATIENT TO COMPLETE	PATIENT NAME: _____ DATE OF BIRTH: _____ EMP #: _____ If not the patient, please indicate insurance cardholder's name: _____ <i>If you are the spouse of cardholder, please attach completed form to that of the insurance cardholder/employee of Crouse Health and/or CMP.</i>																						
	LEVEL 1 INCENTIVE – COMPLETE ALL APPLICABLE REQUIREMENTS																						
PROVIDER TO COMPLETE	Requirement #1 – Primary Care Provider (PCP) Visit with Current Lab Tests <i>all participants</i> Date of PCP Visit: _____ (performed in 2026) If not diabetic , date of Fasting Glucose: _____ (Jan. 1, 2022-Dec. 31, 2026) (Jan. 1, 2022-Dec. 31, 2026) Date of Cholesterol Test: _____ (Jan. 1, 2022-Dec. 31, 2026) If diabetic , date of A1c: _____ (performed in 2026)																						
	Requirement #2: Cervical Cancer Screening (“pap test”) <i>females ages 21-64 as of 04/2025* (*Considers ACOG recommendation)</i> <input type="checkbox"/> N/A -or- <input type="checkbox"/> Exception Applies (Exception: hysterectomy, agenesis, cervix absence) Date: _____ (performed between Jan. 1, 2021 – Dec. 31, 2026) Screening Provider: _____																						
	Requirement #3: Breast Cancer Screening <i>females ages 40 and older as of 5/3/2023*</i> <input type="checkbox"/> N/A -or- <input type="checkbox"/> Exception Applies (Exception: double mastectomy) (*Considers American College of Radiology recommendation) Date: _____ (performed in 2026) Screening Provider: _____ <input type="checkbox"/> Report is in PCP chart (required)																						
	Requirement #4: Colorectal Cancer Screening <i>all participants ages 45-75 as of 5/18/2021* (*Considers USPSTF recommendation)</i> <input type="checkbox"/> N/A -or- <input type="checkbox"/> Exception Applies (Exception: colorectal cancer or total colectomy) Must complete at least one of the below services in timeframe noted (check all that apply): <input type="checkbox"/> Feccal Occult Blood Test performed between Jan. 1, 2026 - Dec. 31, 2026 <input type="checkbox"/> Cologuard performed between Jan. 1, 2024 - Dec. 31, 2026 <input type="checkbox"/> Flexible Sigmoidoscopy or CT Colonography performed between Jan 1. 2022 - Dec. 31, 2026 <input type="checkbox"/> Colonoscopy performed between Jan. 1, 2017 - Dec. 31, 2026 Date: _____ Screening Provider: _____ <input type="checkbox"/> Report is in PCP chart (required)																						
	Requirement #5: Diabetic Retinal Eye Exam* <i>participants diagnosed with Diabetes Type 1 or Type 2</i> <input type="checkbox"/> N/A Date: _____ (performed in 2026) Screening Provider: _____ <input type="checkbox"/> Report is in PCP chart (required)																						
	LEVEL 2 INCENTIVE – MEET HEALTH GOALS WITH “IN RANGE” OR “IMPROVED RESULT” *“Improved Result” = 5% improvement since prior year																						
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;">Health Goals</th> <th style="width: 10%;">Not Met</th> <th style="width: 10%;">In Range</th> <th style="width: 40%;">Improved Result*</th> </tr> </thead> <tbody> <tr> <td>Healthy Weight per PCP</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td><input type="checkbox"/> 2025 Result: _____ 2026 Result: _____</td> </tr> <tr> <td>BP <=130 systolic and <=80 diastolic</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td><input type="checkbox"/> 2025 Result: _____ 2026 Result: _____</td> </tr> <tr> <td>Non-diabetics: Fasting Glucose <= 100 Diabetics: A1c < 8.0% (fasting glucose not required)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td><input type="checkbox"/> 2025 Result: _____ 2026 Result: _____</td> </tr> <tr> <td>LDL < =100</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td><input type="checkbox"/> 2025 Result: _____ 2026 Result: _____</td> </tr> </tbody> </table>				Health Goals	Not Met	In Range	Improved Result*	Healthy Weight per PCP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 2025 Result: _____ 2026 Result: _____	BP <=130 systolic and <=80 diastolic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 2025 Result: _____ 2026 Result: _____	Non-diabetics: Fasting Glucose <= 100 Diabetics: A1c < 8.0% (fasting glucose not required)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 2025 Result: _____ 2026 Result: _____	LDL < =100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 2025 Result: _____ 2026 Result: _____
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“Tobacco Free,” meaning no use in the last 6 months any form of tobacco including, cigarettes, pipes, cigars, smokeless tobacco or vaping. <input type="checkbox"/> Patient has not used tobacco or vaping products in the last 6 months.																							
PCP VERIFICATION (REQUIRED)																							
By signing this form, PCP verifies that the information provided is accurate and consistent with the medical records on file for this patient. Practice Name (Print): _____ Provider Name (Print): _____ Date: _____ Provider Signature: _____																							