City of Kinston Health $ense Program
Employee Health Mangement Agreement

By signing this agreement for participation in the Health $ense Program, I am agreeing to the following:

1. I will read/review notices each year to learn of any changes in requirements for earning Health $ense points. I understand agreements will automatically renew unless changes are made during the plan year that require new signatures.

2. I will complete and submit a "Health Mangement Agreement" in order to be eligible for point reimbursement. This agreement must be received by the coordinator prior to any activity for which I am claiming Health $ense points. A faxed copy is acceptable as long as currently dated, signed and witnessed.

3. I will complete the required affidavits (Health $ense forms) and turn them in as collected as early as possible and all before the final deadline in order to receive points. I understand final payouts will be made in December each year for all employees participating in the plan.

4. I am enrolled in the Health $ense Program on an ongoing basis and do not need to renew this agreement as long as I am employed with the City of Kinston as a regular employee with thirty (30) or more hours per week (not including seasonal or temporary employment), unless changes have been made in the Health Mangement Plan during the year. I understand I must continue enrollment in the City of Kinston Medical Plan and continue to contribute premiums to the plan in order to be eligible to participate in the Health $ense reimbursement program. This provision applies to retirees as well.

5. If my employment with the City of Kinston is terminated for any reason, prior to the date of reimbursement, I understand I will only be eligible for reimbursement of those points accumulated up to the date of termination, not to exceed the amount paid in for my insurance premiums at that point. I understand these payments will be made at the end of the plan period. It will be my responsibility to provide notification information to Employee Health, such as address and phone, in order to receive notification about any eligible payments after my termination.

6. My Reimbursement Record, reflecting my accumulated Health $ense points, will be available to me for viewing in Employee Health. If I do not agree with the balances, I have three (3) days to appeal the amount of reimbursement listed by providing additional new documentation to support my figures. If I do not review or appeal the record by the deadline, it is presumed to be accurate, and that amount will be distributed. I understand October 31 of the plan year will be the deadline for turning in points.

Employee Signature: _____ Date: _____

Printed Name: _____SS Number (last 4 digits) _____

Department: _____

City of Kinston Health $ense Program

A Letter to Healthcare Providers

Plan Year Period: November 1 through October 31 of any given year

Dear Healthcare Provider:

This letter is a brief explanation of the City's Health $ense reimbursement program for participating City of Kinston employees. Due to rising health care and insurance costs, the City requires employees to pay a portion of the costs for individual health insurance coverage. Our Health $ense Program includes a reimbursement system that allows employees to earn Health $ense points that can be converted to cash to offset the cost of this insurance premium, subject to premium payment limits. The program requires documentation in order to credit employees for **preventive** health checks each year. The "Annual Routine Physical Exam" may be conducted without Cholesterol and HDL or HgbAiC depending on the employees medical health. These tests will be done anuually at our Biometiric Screening Event. The prostate screening with PSA, Pap smears, skin and colorectal cancer screenings, and mammography, are in addition to what we are identifying as the Annual Routine Physical Exam and have separate and additional point values. These tests will earn additional Health $ense points for employees with appropriate documentation; however, it is purely the healthcare provider's decision as to the necessity of these tests. The total cost of the annual routine physical exam is covered under the employee's annual wellness benefit at 100% with no co-pays for Wellness, and includes blood work designated as part of the physical, whether done in the doctor's office at the time of the physical or sent out to another participating facility.

We greatly appreciate you and your office staff's willingness to provide this information for the employee. Please understand that we are not making any recommendations concerning the tests that are done on your patient. It is solely up to you and that patient as to what tests are appropriate. Please feel free to contact the Employee Health Clinic with any questions, comments or concerns at 252- 939-3373 or 252-939-3372.

Sincerely,

Michelle Johnson, RN

Michelle Johnson, RN
City of Kinston Employee Health

City of Kinston Health $ense Program

Reimbursement Form

Form A - ANNUAL Routine Physical (one per physician/year)

Employee Name _____ Date of Exam _____

Name of Physician _____

Address of Facility _____

CHECKS DO NOT EARN POINTS...MUST BE INITIALED BY MD or Office Staff

____ ANNUAL Routine Physical Examination W/PERSONAL MD (100)

____ Skin Cancer Screening (10) (one/year)

____ Colorectal Cancer Screening (slide) (10) (one/year)

____ Prostate Cancer Screening and PSA (30) (one/year)

____ Bone Density (10) (one/year)

____ Stress (exercise) EKG (25) (one/year)

____ Colonoscopy (60) (one/year) Signature _____
Gastroenterologist/Office Staff

____ Mammogram (40) (one/year) Signature _____
Radiologist

____ Cervical Cancer Screening (Pap smear) (30) (one/year)

Gynecologist Signature _____

or

Signature of Physician or Office Personnel: _____

City of Kinston Health $ense Program

Form B - Eye Health Screening

Name: _____ Date: _____

Name of Eye Doctor: _____

Address of Facility: _____

Please Initial Below Those Services/Screenings Performed:

____Eye Health and Glaucoma Screening (maximum once/year) (10)
(Vision only does not qualify)

CHECKS WILL NOT EARN POINTS....MUST BE INITIALED BY MD or Office Staff

Signature of Physician or Authorized Office Personnel:

_____ Date: _____

City of Kinston Health $ense Program

Form C - Dental Screening/Cleaning

Name: _____ Date: _____

Name of Dentist: _____

Address of Facility: _____

Please Initial Below Those Services/Screenings Performed:

_____Routine Dental Screening/Cleaning (maximum twice/year) (20)

CHECKS WILL NOT EARN POINTS....MUST BE INITIALED BY DDS or Office Staff

Signature of Dentist or Authorized Office Personnel:

_____ Date: _____

City of Kinston Health $ense Program

Tobacco Use Statement

(10)

I do not smoke or use any tobacco product. I have not smoked or used any tobacco products during this entire Well Bucks Plan Program year: November 1st through October 31st.

I agree that if I fail to comply with my statement of tobacco product non-use I will notify Employee Health and understand I will relinquish my right to the reimbursement points for this category for the current program year.

Printed Name: _____

Signature: _____ Date _____

Witness: _____ Date: _____

City of Kinston Health $ense Program

Fitness Program Statement

Fitness Program: Employees must sign the affidavit stating that they have participated in fitness activities during the plan period (November 1 to October 31). Credit for participation will be awarded based upon thirty (30) day periods. Periods of less than 30 days will not be awarded points. This category may include participation in organized sports (outside of a fitness facility membership) such as volleyball, softball, square dancing, etc. This program requires some regular form of aerobic (strenuous exercise or activity that causes a temporary marked increase in heart and respiration rate) at least 3 - 4, preferably 5, days a week per month. This can be running, walking, jogging, biking, swimming, skiing, sports, etc.

Specific guidelines for requirements on earning Health $ense points for **fitness program participation** are as follows: Employees need to participate in their physical fitness activity no less than an average of three times each week during each 30 day period they claim. It is recommended that, for good health, we exercise aerobically no less than 30 minutes a day most days a week. The City recognizes that sedentary individuals need to start somewhere and is encouraging participation, thus we do not ***require*** 5 -7 days a week of fitness activity for Health $ense credits, although it is recommended by the American College of Sports Medicine (ACSM). Credit for participation will be awarded based upon an **average of 3 times each week** during each thirty (30) day period.
Health $ense Focus Activities are included in this group. Focus activities may include participation in non-profit fund-raisers such as: "Walk for the Cure" -American Diabetes Association; "Relay for Life" - American Cancer Society, ALS Walk, Torch Run and others. Average these activities in for month.

Employee Name (PRINT): _____

Period of participation: (Average of 3 times each week during each thirty day period)
(10/month - max 100/year)

_____ November 1 - November 30	_____ May 1 - May 31
_____ December 1 - December 31	_____ June 1 - June 30
_____ January 1 - January 31	_____ July 1 - July 31
_____ February 1 - February 29 (28)	_____ August 1 - August 31
_____ March 1- March 31	_____September 1 - September 30
_____ April 1 - April 30	_____ October 1 - October 31

Employee Signature: _____ Date _____

Revised: 10/11/17

City of Kinston Health $ense Program

Flu Immunization Affidavit

Employee must obtain the signature of the professional administering the immunization. The professional is to initial beside the immunizations given and sign below. Immunizations must be received during the Health $ense Program plan year/period in order to be eligible for Health $ense points: Nov 1 through Oct. 31 of plan year.

Immunizations Eligible for Health $ense Points: ***(15)***

Flu (Influenza) _____

Employee Name (Print): _____

Employee Signature: _____

Professional's Signature: _____ **Date:** _____

City of Kinston Health $ense Program

Compass Engagement (max of 100 points per year)

- Compass Registration (1-time only) **(50)** current registrants not permitted
- Doctor Recommendations **(25)**
- Cost Estimate for Recommended Procedure and/or Radiology Test (X-rays, CT scan, MRI, etc.) **(50)**
- Prescription Reviews **(50)**

Teladoc "visit" (10 points per visit/max of 20 points per year)

- Your participation or usage with Compass and Teladoc will be provided in monthly reports sent to Human Resources. You may contact Human Resources to ensure your points are noted.

Quarterly Meeting Attendance (15 Points per meeting/max of 60 points per year)

Health $ense meetings will be once every quarter. The Employee Health Nurse will notify employees of the topics, times, and locations of the quarterly meeting. Please make sure you sign the attendance record before leaving the meeting.