WOOD COUNTY EMPLOYEE HEALTH BENEFITS PLAN – Please note two signatures are required.

Name: ________________________________ **Department:** ___________________________________

ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge receipt of my Individual Enrollment Verification as of November 1, 2023 (if enrolled in coverage).

- Your current coverage will automatically renew for the 2024 plan year. You may request changes during the Open Election Period (Nov. 15 to Dec. 15, 2023) by submitting a Universal Application to your Insurance Group Representative **by 4:00 p.m. on Friday, December 15, 2023.** Refer to the Plan Document for opportunities to make mid-year changes.
- **A separate sign-off for the Individual Enrollment Verification is required. Review this information carefully. Any changes must be submitted on a Universal Application. Return your signed IEV to your Insurance Group Representative by November 30 with this form and application, if applicable.**

I hereby acknowledge receipt of the 2024 Summary Plan Description.

I hereby acknowledge access to the following, either on the Wood County employee website or through my Insurance Group Representative: Plan Document, Summary of Benefits and Coverage, and Glossary of Health Coverage and Medical Terms.
I understand it is my responsibility to report to the Plan any changes that affect insurance coverage as required.

Employee Signature: ____________________________________ **Date:**_____________

WELLNESS PROGRAMS WAIVER & RELEASE

Throughout the year, I may voluntarily participate in the Wellness Programs provided by the Plan including but not limited to those listed in the 2024 Summary Plan Description. In the event that I elect to participate in one or more of the programs, I agree to the representations, acknowledgements, and release and waiver as stated below.

- I acknowledge that upon starting a Wellness Program, I am physically capable of participating in such a program and I have received approval for participation by my personal physician.
- I acknowledge the risks of illness or injury inherent in the Wellness Programs.
- I hereby release and waive any and all claims against the "Wood County Wellness Programs," its developers, staff, agents, or sponsors of the program from any injuries, claims, costs, damages, liability, or judgments, and all rights to compensation benefits under Chapter 4123 of the Revised Code (Workers' Compensation), arising out of my voluntary membership and participation in the Wellness Programs.
- I understand and acknowledge that the Wellness Programs may involve independent trainers/facilities that provide facility, equipment, personnel and programs to voluntary participants employed by Wood County. (To qualify as a reimbursable provider, the provider must comply with facility criteria as posted on the Wood County wellness website, (www.woodcountyohio.gov) Said programs have sole control over the manner and mode of the services they provide to Wood County Employees who become members of such Facility/Program.
- I understand the Plan may provide reimbursement for specific Wellness Programs to those eligible employees who voluntarily enroll and complete program requirements (utilization, deadline requirements, etc.). The amount reimbursed shall not exceed the specified maximum reimbursement and in no case shall reimbursement exceed the amount paid to the facility/program for the specified period. The Plan does not reimburse for ancillary services (i.e., food/drinks, tanning, massages, supplies, child care, etc.), recreational teams, individual sports programs, or programs covered by insurance. I further understand that any reimbursement is considered a taxable fringe benefit and will be included as employee compensation for federal, state, and local taxes.
- I further understand that Wood County assumes no other role nor undertakes any other function with regard to services provided by the Wellness Programs.
- I understand that submission of fraudulent documents may constitute insurance fraud and may result in denial of reimbursement and deductible credit, if applicable.

I have carefully read and fully understand this document.

This waiver and release shall apply to and be binding upon my heirs, executors, administrators, successors, and assigns.

Employee Signature: ____________________________________ **Date:**_____________

Return signed form to your Insurance Group Representative by November 30, 2023.

Employees hired prior to October 9, 2022, were measured for benefit eligibility for the 2024 Plan Year under the Standard Look-Back Method. Notification will be made to employees whose benefit-eligibility status changes. Refer to the Summary Plan Description for additional information. Questions regarding your eligibility can be directed to the Benefits Clerk at 419.354.9100.