

CERTIFICATE OF INSURANCE

Legislative changes effective January 1, 2012 are not included in this document. An updated Evidence of Coverage will be available by January 31, 2012

A description of Your plan

EOCID 341695

Commercial Pharmacy Wrap Plan (Plan CW9) Effective 1/1/2012

Important benefit information – please read



Health Net®

LIFE INSURANCE COMPANY

UNIVERSITY OF CALIFORNIA ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS

January 1, 2012

The following information applies to the University of California plan and supersedes any corresponding information that may be contained elsewhere in the document to which this insert is attached. The University establishes its own medical plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations ("Regulations") and any corresponding Administrative Supplements. Portions of these Regulations are summarized below.

ELIGIBILITY

The following individuals are eligible to enroll in this Plan. If the Plan is a Health Maintenance Organization (HMO) or Exclusive Provider Organization (EPO) Plan, they are only eligible to enroll in the Plan if they meet the Plan's geographic service area criteria. Anyone enrolled in a non-University Medicare Advantage Managed Care contract or enrolled in a non-University Medicare Part D Prescription Drug Plan will be disenrolled from this health plan.

Subscriber

Employee: You are eligible if you are appointed to work at least 50% time for twelve months or more or are appointed at 100% time for three months or more or have accumulated 1,000* hours while on pay status in a twelve-month period. To remain eligible, you must maintain an average regular paid time** of at least 17.5 hours per week and continue in an eligible appointment. If your appointment is at least 50% time, your appointment form may refer to the time period as follows: "Ending date for funding purposes only; intent of appointment is indefinite (for more than one year)."

* Lecturers - see your benefits office for eligibility.

** Average Regular Paid Time - For any month, the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked in the preceding twelve (12) month period. Average regular paid time does not include full or partial months of zero paid hours when an employee works less than 43.75% of the regular paid hours available in the month due to furlough, leave without pay or initial employment.

Retiree: A former University Employee receiving monthly benefits from a University-sponsored defined benefit plan. You may continue University medical plan coverage as a Retiree when you start collecting retirement or disability benefits from a University-sponsored defined benefit Plan provided that you must also meet the following requirements:

- (a) you meet the University's service credit requirements for Retiree medical eligibility;
- (b) the effective date of your Retiree status is within 120 calendar days of the date employment ends; and
- (c) you elect to continue (or suspend) medical coverage at the time of retirement.

A **Survivor**—a deceased Employee's or Retiree's Family Member receiving monthly benefits from a University-sponsored defined benefit plan—may be eligible to continue coverage as set forth in the University's Group Insurance Regulations. For more information, see the *UC Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members* or the *Survivor and Beneficiary Handbook*.

If you are eligible for Medicare, you must follow UC's Medicare Rules. See "Effect of Medicare on Retiree Enrollment" below.

Eligible Dependents (Family Members)

When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member meets the eligibility requirements outlined below. The University and/or the Plan reserves the right to periodically request documentation to verify eligibility of Family Members, including any who are required to be your tax dependent(s). Documentation could include a marriage certificate, birth certificate(s), domestic partner verification, adoption records, court documentation confirming a child's status as a legal ward Federal Income Tax Return, or other official documentation.

Eligible Adult: You may enroll one eligible adult Family Member, in addition to yourself

Spouse: Your legal spouse.

Domestic Partner:

You may enroll your same-sex domestic partner if your partnership is registered with the State of California or otherwise meets criteria as a domestic partnership as set forth in the University of California Group Insurance Regulations. Same-sex domestic partners from jurisdictions other than California will be covered to the extent required by law. You may enroll your opposite-sex domestic partner only if either you or your domestic partner is age 62 or older and eligible to receive Social Security benefits based on age. Your domestic partner (same-sex or opposite sex) must be at least 18 years of age.

Note: An adult dependent relative is not eligible for coverage in UC plans (unless enrolled prior to December 31, 2003 and continuously eligible and enrolled since that date (e.g., continues to be ineligible for Medicare Part A)).

Child:

All eligible children must be under the limiting age of 26 (18 for legal wards) except for a child who is incapable of self-support due to a physical or mentally disabling injury, illness or condition. The following categories are eligible:

- (a) your natural or legally adopted children;
- (b) your spouse's natural or legally adopted children (your stepchildren);
- (c) your eligible domestic partner's natural or legally adopted children;
- (d) grandchildren of you, your spouse or your eligible domestic partner if unmarried, living with you, dependent on you, your spouse or your eligible domestic partner for at least 50% of their support and are your, your spouse's, or your eligible domestic partner's dependents for income tax purposes;
- (e) children for whom you are the legal guardian if unmarried, living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.
- (f) children for whom you are legally required to provide group health insurance pursuant to an administrative or court order. (Child must also meet UC eligibility requirements.)

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental disability may continue to be covered past age 26 provided:

- the plan-certified disability began before age 26, the child was enrolled in a UC group medical plan before age 26 and coverage is continuous;
- the child is chiefly dependent upon you, your spouse, or your eligible domestic partner for support and maintenance (50% or more); and

- the child is claimed as your, your spouse's, or your eligible domestic partner's dependent for income tax purposes, or if not claimed as such dependent for income tax purposes, is eligible for Social Security Income or Supplemental Security Income as a disabled person or working in supported employment which may offset the Social Security or Supplemental Security Income.

Application for coverage beyond age 26 due to disability must be made to the Plan sixty days prior to the date coverage is to end due to reaching limiting age. If application is received timely but Plan does not complete determination of the child's continuing eligibility by the date the child reaches the Plan's upper age limit, the child will remain covered pending Plan's determination. The Plan may periodically request proof of continued disability, but not more than once a year after the initial certification. Disabled children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required; however, the new Plan may require proof of continued disability, but not more than once a year.

If you are a newly hired Employee with a disabled child over age 26 or if you newly acquire a disabled child over age 26 (through marriage, adoption, or domestic partnership), you may also apply for coverage for that child. The child's disability must have begun prior to the child turning age 26. Additionally, the child must have had continuous group medical coverage since age 26, and you must apply for University coverage during your Period of Initial Eligibility. The Plan will ask for proof of continued disability, but not more than once a year after the initial certification.

Important Note: The University complies with federal and state law in administering its group insurance programs. Health and welfare benefits and eligibility requirements, including dependent eligibility requirements are subject to change (e.g., for compliance with applicable laws and regulations). The University also complies with federal and state income tax laws which are subject to change. Requirements may include laws mandating that the employer contribution for coverage provided to certain Family Members be treated as imputed income to the Employee. See *At Your Service* online for related information. Contact your tax advisor for additional information.

No Dual Coverage

Eligible individuals may be covered under only one of the following categories: as an Employee, a Retiree, a Survivor or a Family Member. If an Employee and the Employee's spouse or domestic partner are both eligible Subscribers, each may enroll separately or one may enroll and cover the other as a Family Member. If they enroll separately, neither may enroll the other as a Family Member. Eligible children may be enrolled under either parent's or eligible domestic partner's coverage but not under both. Additionally, a child who is also eligible as an Employee may not have dual coverage through two University-sponsored medical plans.

More Information

For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's (UC) Customer Service Center at (800) 888-8267. You may also access eligibility factsheets on UC's *At Your Service* web site: <http://atyourservice.ucop.edu>.

ENROLLMENT

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. If you are a Retiree, contact the UC Customer Service Center. Enrollment transactions may be completed by paper form or electronically, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits office or by the UC Customer Service Center by the last business day within the applicable enrollment period. Electronic transactions must be completed by the deadline on the last day of the enrollment period.

During a Period of Initial Eligibility (PIE)

A PIE begins the day you become eligible and ends 31 days after it began (but see exception under “Special Circumstances” paragraph 1.d below). Also see “At Other Times for Employees and Retirees” below. If the last day of a PIE falls on a weekend or holiday, the PIE is extended to the following business day if you are enrolling with paper forms.

If you are an Employee, you may enroll yourself and any eligible Family Members during your PIE. Your PIE starts the day you become an eligible Employee.

You may enroll any newly eligible Family Member during his or her PIE. The Family Member's PIE starts the day your Family Member becomes eligible, as described below. During this PIE you may also enroll yourself and/or any other eligible Family Member if not enrolled during your own or their own PIE. You must enroll yourself in order to enroll any eligible Family Member. Family Members are only eligible for the same plan in which you are enrolled.

- (a) For a spouse, on the date of marriage.
- (b) For a Domestic Partner, on the date the domestic partnership is legally established. Also see “At Other Times for Employees and Retirees” below.
- (c) For a natural child, on the child's date of birth.
- (d) For an adopted child, the earlier of:
 - (i) the date the child is placed for adoption with the Employee/Retiree, or
 - (ii) the date the Employee/Retiree or Spouse/Domestic Partner has the legal right to control the child's health care.

A child is “placed for adoption” with the Employee/Retiree as of the date the Employee/Retiree assumes and retains a legal obligation for the child's total or partial support in anticipation of the child's adoption.

If the child is not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date the adoption becomes final.

- (e) For a legal ward, the effective date of the legal guardianship
- (f) Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you are in a Health Maintenance Organization (HMO), Exclusive Provider Organization (EPO), or Point of Service (POS) Plan and you move or are transferred out of that Plan's service area, or will be away from the Plan's service area for more than two months, you will have a PIE to enroll yourself and your eligible Family Members in another University medical plan available in the new location. Your PIE starts with the effective date of the move or the date you leave the Plan's service area. Upon return to the service area, you will have a PIE to reenroll yourself and eligible Family Members in the same HMO, EPO or POS you had at the time of the move out of the area. The PIE begins with the effective date of the return to the service area.

At Other Times for Employees and Retirees

Open Enrollment Period. You and your eligible Family Members may also enroll during a group open enrollment period established by the University.

90-Day Waiting Period. If you are an Employee and opt out of medical coverage or fail to enroll yourself during a PIE or open enrollment period, you may enroll yourself at any other time upon completion of a 90 consecutive calendar day waiting period unless one of the “Special Circumstances” described below applies.

If you are an Employee or Retiree and fail to enroll your eligible Family Members during a PIE or open enrollment period, you may enroll your eligible Family Members at any other time upon completion of a 90 consecutive calendar day waiting period unless one of the “Special Circumstances” described below applies.

The 90-day waiting period starts on the date the enrollment form is received by the local Accounting or Benefits office and ends 90 consecutive calendar days later.

Newly Eligible Child. If you have one or more children enrolled in the Plan, you may add a newly eligible Child at any time. See "Effective Date".

Special Circumstances. You may enroll before the end of the 90-day waiting period or without waiting for the University’s next open enrollment period if you are otherwise eligible under any one of the circumstances set forth below:

1. You have met all of the following requirements:
 - a. You were covered under another health plan as an individual or dependent, including coverage under COBRA or CalCOBRA (or similar program in another state), the Children’s Health Insurance Program or “CHIP” (called the Healthy Families Program in California), or Medicaid (called Medi-Cal in California).
 - b. You stated at the time you became eligible for coverage under this Plan that you were declining coverage under this Plan or disenrolling because you were covered under another health plan as stated above.
 - c. Coverage under another health plan for you and/or your eligible Family Members ended because you/they lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, your coverage under COBRA or Cal-COBRA continuation was exhausted, or coverage under CHIP or Medicaid was lost because you/they were no longer eligible for those programs.
 - d. You properly file an application with the University during the PIE which starts on the day after the other coverage ends. **Note that if you lose coverage under CHIP or Medicaid, your PIE is 60 days.**
2. You or your eligible Family Members are not currently enrolled in the UC-sponsored medical coverage and you or your eligible Family Members become eligible for premium assistance under the Medi-Cal Health Insurance Premium Payment (HIPP) Program or a Medicaid or CHIP premium assistance program in another state. Your PIE is 60 days from the date you are determined eligible for premium assistance. If the last day of the PIE falls on a weekend or holiday, the PIE is extended to the following business day if you are enrolling with paper forms.
3. A court has ordered coverage be provided for a dependent child under your UC-sponsored medical plan pursuant to applicable law and an application is filed within the PIE which begins the date the court order is issued. The child must also meet UC eligibility requirements.
4. You have a change in family status through marriage or domestic partnership, or the birth, adoption, or placement for adoption of a child:

- a. If you are enrolling following marriage or establishment of a domestic partnership, you and your new spouse or domestic partner must enroll during the PIE. Your new spouse or domestic partner's eligible children may also enroll at that time. Coverage will be effective as of the date of marriage or domestic partnership provided you enroll during the PIE.
- b. If you are enrolling following the birth, adoption, or placement for adoption of a child, your spouse or domestic partner, who is eligible but not enrolled, may also enroll at that time. Application must be made during the PIE; coverage will be effective as of the date of birth, adoption, or placement for adoption provided you enroll during the PIE.

If you are a Retiree, you may continue coverage for yourself and your enrolled Family Members in the same plan (or its Medicare version) you were enrolled in immediately before retiring, and you may change your plan during the University's next open enrollment period. You must elect to continue enrollment for yourself and enrolled Family Members before the effective date of retirement (or the date disability or survivor benefits begin). Retirement alone does not grant a PIE to enroll or change your medical plan.

If you are a Survivor, you may not enroll your legal spouse or domestic partner.

Effective Date

The following effective dates apply provided the appropriate enrollment transaction (paper form or electronic) has been completed within the applicable enrollment period.

If you enroll during a PIE, coverage for you and your Family Members is effective the date the PIE starts.

If you are a Retiree continuing enrollment in conjunction with retirement, coverage for you and your Family Members is effective on the first of the month following the first full calendar month of retirement income.

The effective date of coverage for enrollment during an open enrollment period is the date announced by the University.

For enrollees who complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment transaction is completed.

An Employee or Retiree already enrolled in adult plus child(ren) or family coverage may add additional children, if eligible, at any time after their PIE. Retroactive coverage is limited to the later of:

- (a) the date the Child becomes eligible, or
- (b) a maximum of 60 days prior to the date your Child's enrollment form is received by your local Benefits or Payroll Office.

Change in Coverage

In order to make any of the changes described above, contact the person who handles benefits at your location (or the UC Customer Service Center if you are a Retiree).

Effect of Medicare on Retiree Enrollment

If you are a Retiree and you and/or an enrolled Family Member is or becomes eligible for premium-free Medicare Part A (Hospital Insurance) as primary coverage, then that individual must also enroll in and remain in Medicare Part B (Medical Insurance). This includes anyone who is entitled to Medicare benefits through their own or their spouse's employment. Individuals enrolled in both Part A and Part B are then eligible for the Medicare premium applicable to this plan.

Retirees or their Family Member(s) who become eligible for premium-free Medicare Part A on or after January 1, 2004 and do not enroll in and continue Part B will permanently lose their UC-sponsored medical coverage.

Retirees and their Family Members who were eligible for premium-free Medicare Part A between July 1, 1991 and January 1, 2004, but declined to enroll in Part B of Medicare, are assessed a monthly offset fee by the University to cover increased costs. The offset fee may increase annually, but will stop when the Retiree or Family Member becomes covered under Part B.

Retirees or Family Members who are not eligible for premium-free Part A will not be required to enroll in Part B, they will not be assessed an offset fee, nor will they lose their UC-sponsored medical coverage. Documentation attesting to their ineligibility for Medicare Part A will be required. (Retirees/Family Members who are not entitled to Social Security and premium-free Medicare Part A will not be required to enroll in Part B.)

An exception to the above rules applies to Retirees or Family Members in the following categories who will be eligible for the non-Medicare premium applicable to this plan and will also be eligible for the benefits of this plan without regard to Medicare:

- a) Individuals who were eligible for premium-free Part A, but not enrolled in Medicare Part B prior to July 1, 1991.
- b) Individuals who are not eligible for premium-free Part A.

You should contact Social Security three months before your or your Family Member's 65th birthday to inquire about your eligibility and how to enroll in Part A and Part B of Medicare. If you qualify for disability income benefits from Social Security, contact a Social Security office for information about when you will be eligible for Medicare enrollment.

Upon Medicare eligibility, you or your Family Member must complete a University of California *Medicare Declaration* form, as well as submit a copy of your Medicare card. This notifies the University that you are covered by Part A and Part B of Medicare. The University's *Medicare Declaration* form is available through the UC Customer Service Center or from the web site:

<http://atyourservice.ucop.edu>. Completed forms should be returned to University of California, Human Resources, Retiree Insurance Program, Post Office Box 24570, Oakland, CA 94623-1570.

Any individual enrolled in a University-sponsored Medicare Advantage Managed Care contract must assign his/her Medicare benefit (including Part D) to that plan or lose UC-sponsored medical coverage. Anyone enrolled concurrently in a non-University Medicare Advantage Managed Care contract will be disenrolled from this health plan. Any individual enrolled in a University-sponsored Medicare Part D Prescription Drug Plan must assign his/her Part D benefit to the plan or lose UC-sponsored medical coverage. Anyone enrolled concurrently in a non-University Medicare Part D Prescription Drug Plan will be disenrolled from this health plan.

Medicare Secondary Payer Law (MSP)

The Medicare Secondary Payer (MSP) Law affects the order in which claims are paid by Medicare and an employer group health plan. Employees or their spouses, age 65 or over, and UC Retirees rehired into positions making them eligible for UC-sponsored medical coverage, including CORE and mid-level benefits, are subject to MSP. For those eligible for a group health plan due to employment, MSP indicates that Medicare becomes the secondary payer and the employer plan becomes the primary payer. You and your spouse should carefully consider the impact on your health benefits and premiums at age 65 or should you decide to return to work after you retire.

Medicare Private Contracting Provision and Providers Who do Not Accept Medicare

Federal Legislation allows physicians or practitioners to opt out of Medicare. Medicare beneficiaries wishing to continue to obtain services (**that would otherwise be covered by Medicare**) from these physicians or practitioners will need to enter into written "private contracts" with these physicians or practitioners. These private agreements will require the beneficiary to be responsible for all payments to such medical providers. Since services provided under such "private contracts" are not covered by Medicare or this Plan, the Medicare limiting charge will not apply.

Some physicians or practitioners have **never** participated in Medicare. Their services (that would be covered by Medicare if they participated) will not be covered by Medicare or this Plan, and the Medicare limiting charge will not apply.

If you are classified as a Retiree by the University (or otherwise have Medicare as a primary coverage), are enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement as described above with one or more physicians or practitioners, or if you choose to obtain services from a provider who does not participate in Medicare, under the law you have in effect "opted out" of Medicare for the services provided by these physicians or other practitioners. In either case, no benefits will be paid by this Plan for services rendered by these physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered. Therefore, it is important that you confirm that your provider takes Medicare prior to obtaining services for which you wish the Plan to pay.

However, even if you do sign a private contract or obtain services from a provider who does not participate in Medicare, you may still see **other** providers who have not opted out of Medicare and receive the benefits of this Plan for those services.

TERMINATION OF COVERAGE

The termination of coverage provisions that are established by the University of California in accordance with its Regulations are described below. Additional Plan provisions apply and are described elsewhere in the document.

Deenrollment Due to Loss of Eligible Status

If you are an Employee and lose eligibility, your coverage and that of any enrolled Family Member stops at the end of the last month for which premiums are taken from earnings based on an eligible appointment. If you are hospitalized or undergoing treatment of a medical condition covered by this Plan, benefits will cease to be provided and you may have to pay for the cost of those services yourself. You may be entitled to continued benefits under terms, which are specified elsewhere in this document. (If you apply for an individual HIPAA or conversion plan, the benefits may not be the same as you had under this Plan.)

If you are a Retiree or Survivor and your monthly retirement payments covered by a University-sponsored defined benefit plan, your coverage and that of any enrolled Family Member stops at the end of the last month in which you are eligible for the retirement income.

If your Family Member loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the Family Member is no longer eligible. Coverage stops at the end of the month in which he or she no longer meets all the eligibility requirements. For information on deenrollment procedures, contact the person who handles benefits at your location (or the UC Customer Service Center if you are a Retiree).

Deenrollment Due to Fraud or Intentional Misrepresentation

Coverage for you and/or your Family Members may be suspended for up to 12 months if you or a Family Member commit fraud or make an intentional misrepresentation of material fact relating to Plan coverage. Individuals who are enrolled, but who are not eligible Family Members will be permanently deenrolled.

Leave of Absence, Layoff, Change in Employment Status or Retirement

Contact your local Benefits Office for information about continuing your coverage in the event of an authorized leave of absence, layoff, change of employment status, or retirement.

Optional Continuation of Coverage

As a participant in this plan you may be entitled to continue health care coverage for yourself, spouse or family members if there is a loss of coverage under the plan as a result of a qualifying event under the terms of the federal COBRA continuation requirements under the Public Health Service Act, as amended, and, if that continued coverage ends, you may be eligible for further continuation under California law. You or your family members will have to pay for such coverage. You may direct questions about these provisions to CONEXIS, UC's COBRA administrator or visit the website: http://atyourservice.ucop.edu/employees/health_welfare/cobra.html

Contract Termination

Coverage under the Plan is terminated when the group contract between the University and the Plan Vendor is terminated. Benefits will cease to be provided as specified in the contract and you may have to pay for the cost of those benefits yourself. You may be entitled to continued benefits under terms which are specified elsewhere in this document. (If you apply for an individual HIPAA or conversion plan, the benefits may not be the same as you had under this Plan.)

PLAN ADMINISTRATION

By authority of the Regents, University of California Human Resources, located in Oakland, California, administers this plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and applicable state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by the Regents. The terms of those documents apply if information in this document is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this document and/or the group insurance contracts. What is written in this document does not constitute a guarantee of plan coverage or benefits--particular rules and eligibility requirements must be met before benefits can be received. .

This section describes how the Plan is administered and what your rights are.

Sponsorship and Administration of the Plan

The University of California is the Plan sponsor and the President of the University (or his/her delegates) is the Plan Administrator for the Plan provisions described in this insert to the Plan Evidence of Coverage booklet. If you have a question about eligibility or enrollment, you may direct it to:

University of California
Human Resources
300 Lakeside Drive
Oakland, CA 94612
(800) 888-8267

Retirees and Survivors may also direct questions to the UC Customer Service Center at the above phone number.

Claims and appeals for benefits under the Plan are processed by Health Net. If you have a question about benefits under the Plan or about a specific claim, please contact Health Net at the following address and phone number:

Health Net
P.O. Box 10198
Van Nuys, CA 91410-09108
1-800-539-4072

Group Contract Number

The Group Contract Number for this Plan is: 5047RC, G, M, R, V, Z, 5047SD, J, N, S, W, 5047TB, H, M, S, X, 5047UC, G, M, T, Y, 5047VC, H

Type of Plan

This Plan provides group medical care benefits. This Plan is one of the benefit plans offered under the University of California Health and Welfare Programs for eligible Faculty and Staff.

Plan Year

The plan year is January 1 through December 31.

Continuation of the Plan

The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. Plan benefits are not accrued or vested benefit entitlements. The right to terminate or amend applies to all Employees, Retirees and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The portion of the premiums that University pays is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation.

Financial Arrangements

The benefits under the Plan are provided by Health Net under a Standardized Contract. The cost of the premiums is currently shared between you and the University of California.

Agent for Serving of Legal Process

Legal process may be served on Health Net at the address listed above.

Your Rights under the Plan

As a participant in a University of California medical plan, you are entitled to certain rights and protections. All Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and other specified sites, all Plan documents, including the Standardized Contract, at a time and location mutually

convenient to the participant and the Plan Administrator.

- Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

-

Claims under the Plan

To file a claim or to file an appeal regarding denied claims of benefits or services, refer to the appeal section found later in this document. Any appeals regarding coverage denials that relate to eligibility requirements are subject to the UC Group Insurance Regulations. To obtain a copy of the Eligibility Claims Appeal Process, please contact the person who handles benefits at your location (or the UC Customer Service Center if you are a retiree).

Nondiscrimination Statement

In conformance with applicable law and University policy, the University of California is an affirmative action/equal opportunity employer.

Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director of Diversity and Employee Programs, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Director of Academic Affirmative Action, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

Special Reinstatement Rule For Reservists Returning From Active Duty

Reservists ordered to active duty on or after January 1, 2007 who were covered under this Plan at the time they were ordered to active duty and their eligible dependents will be reinstated without waiting periods or exclusion of coverage for pre-existing conditions. A reservist means a member of the U.S. Military Reserve or California National Guard called to active duty as a result of the Iraq conflict pursuant to Public Law 107-243 or the Afghanistan conflict pursuant to Presidential Order No. 13239. Please notify the Group when you return to employment if you want to reinstate your coverage under the Plan.

Special Reinstatement Rule Under USERRA

USERRA, a federal law, provides service members returning from a period of uniformed service who meet certain criteria with reemployment rights, including the right to reinstate their coverage without pre-existing exclusions or waiting periods, subject to certain restrictions. Please check with your Group to determine if you are eligible.

Effect of Medicare

If you are eligible for Medicare, you must enroll in Medicare according to UC's Medicare Rules. Once you and/or a family member are enrolled in Medicare, you are ineligible for mental health and substance abuse benefits through the United Behavioral Health portion of your plan. Employees should contact the local benefits office and Retirees should contact the University's Customer Service Center to transfer to the portion of your plan for Medicare enrollees.

**HEALTH NET LIFE COMMERCIAL PHARMACY WRAP CERTIFICATE OF
INSURANCE**

**ISSUED IN CONNECTION WITH THE HEALTH NET LIFE COMMERCIAL
PHARMACY WRAP GROUP POLICY**

**UNDERWRITTEN
BY**

HEALTH NET LIFE INSURANCE COMPANY
Los Angeles, California

HEALTH NET LIFE INSURANCE COMPANY (herein called "HNL") agrees to provide benefits as described in this Certificate to You and Your eligible Dependents, subject to the terms and conditions of the HNL Commercial Pharmacy Wrap Insurance Policy (the Policy) which is issued to the Group.

This *Certificate* provides benefits for covered Prescription Drugs only, and does not provide coverage for medical services. This HNL Commercial Pharmacy Wrap Plan (herein called "Plan") coordinates benefits with Your Medicare Part D Prescription Drug plan and will only cover drugs that are payable to You under Your Medicare Part D Prescription Drug plan.

THE TERMS "YOU" OR "YOUR," WHEN THEY APPEAR IN THIS CERTIFICATE, REFER TO THE PRINCIPAL COVERED PERSON (THE ENROLLED EMPLOYEE/RETIREE). THE TERMS "WE," "OUR" OR "US," WHEN THEY APPEAR IN THIS CERTIFICATE, REFER TO HNL. PLEASE REFER TO "COVERED PERSON" AND "HNL" IN THE "DEFINITIONS" SECTION FOR MORE INFORMATION.

Additionally, special words used in this *Certificate* to explain Your Plan have their first letter capitalized and appear in the "Definitions" section.

If You Are Enrolled In An Employer Plan That Is Subject To ERISA, 29 U.S.C. 1001 et seq., a federal law regulating some employer plans:

IN ADDITION TO THE RIGHTS SET FORTH IN THIS CERTIFICATE, YOU MAY HAVE RIGHTS UNDER APPLICABLE STATE LAW OR REGULATIONS AND/OR UNDER THE FEDERAL ERISA STATUTE.

If You Are Enrolled In A Plan That Is Not Subject To ERISA:

IN ADDITION TO THE RIGHTS SET FORTH IN THIS CERTIFICATE, YOU MAY HAVE RIGHTS UNDER APPLICABLE STATE OR FEDERAL LAWS OR REGULATIONS.

Contact Your Employer to determine if You are enrolled in a plan that is subject to ERISA.

Important Notice To California Certificate Holders

In the event that You need to contact someone about Your insurance coverage for any reason, please contact:

**Health Net Life Insurance Company
P.O. Box 10348
Van Nuys, CA 91049
-800-539-4072**

If You have been unable to resolve a problem concerning Your insurance coverage, after discussions with Health Net Life Insurance Company, or its agent or other representative, You may contact:

**California Department of Insurance, Consumer Services Division
300 South Spring Street
South Tower
Los Angeles, CA 90013
1-800-927-HELP**

Table of Contents

Schedule of Benefits	1
Plan Specific Out-of-Pocket Maximum.....	1
Copayments and Coinsurance.....	1
Covered Benefits	2
The List of Covered Drugs (“Formulary” or “Drug List”).....	2
Prior Authorization	2
Copayment/Coinsurance Tiers.....	2
Network Pharmacies	3
Out-of-Network Pharmacies	3
Mail Order Program.....	4
Off-Label Drugs.....	4
General Limitations and Exclusions	5
Coordination of Benefits.....	6
Grievance, Appeals and Arbitration	6
Grievance and Appeals Procedures	6
Arbitration.....	7
Miscellaneous Provisions.....	8
Notice Of Privacy Practices.....	12
Definitions.....	16
Notice of Language Services	19

SCHEDULE OF BENEFITS

The following is only a brief summary of the benefits covered under this *Certificate*. Please read the entire *Certificate* for complete information about the benefits, conditions, limitations and exclusions of this Plan.

Plan Specific Out-of-Pocket Maximum

Once Your Copayment and Coinsurance payments total the amount shown below in a Calendar Year, You will not pay any more Copayment/Coinsurance for Covered Drugs for the rest of the Calendar Year. All expenses that apply to out-of-pocket maximum will be automatically calculated by Us.

Calendar Year Out-of-Pocket Maximum..... \$2,000

Copayments and Coinsurance

You will be charged the following Copayment or Coinsurance for each Prescription Drug Order

Covered Prescription Drugs	Retail Pharmacy (up to a 30-day supply)	Retail Pharmacy (up to a 90-day supply)	UC Walk-Up service through UC Medical Center Pharmacies or Mail-Order Pharmacy (up to a 90-day supply)
Tier 1 (Preferred Generic Drugs)	\$5	\$15	\$10
Tier 2 (Preferred Brand Drugs)	\$20	\$60	\$40
Tier 3 (Non-Preferred Brand Drugs)	\$35	\$105	\$70
Tier 4 (Injectable Drugs)	25%	25%	25%
Tier 5 (Specialty Drugs)	25%	25%	25%
Erectile Dysfunction	50%	Not Covered	50%

Notes:

- Some Covered Drugs may require Prior Authorization to be covered.
- When there is a generic version of a Brand Name Drug available, our Network Pharmacies will usually dispense the generic version. The Brand Name Drug will usually be available for Your Tier 3 Copayment.
- If a drug that is not on Our Drug List is payable under Your Medicare Part D Prescription Drug plan, such drug is also covered under this *Certificate* subject to the Tier 3 Copayment.

- Prescription Drugs for the treatment of diabetes (including insulin) are covered as stated in the Formulary.
- Some retail Network Pharmacies may provide up to a 90-day supply of Maintenance Drugs for a Copayment per 30-day supply. Please check with Your retail pharmacy to see if this service is available to you.
- Prescription Drugs for sexual or erectile dysfunction are limited to 4 doses per month.

COVERED BENEFITS

This Plan generally covers Prescription Drugs that are:

- On the Plan's List of Covered Drugs (Formulary) (we call it the "Drug List" for short),
- Filled by a Network Pharmacy or through the Plan's mail-order service, and,
- "Medically necessary," meaning reasonable and necessary for treatment for Your illness or injury. It also needs to be an accepted treatment for Your medical condition.

You are responsible for the applicable Deductible, Copayment or Coinsurance, as shown in the "Schedule of Benefits" section of this *Certificate*. The following provisions explain the Plan's coverage in more details.

The List of Covered Drugs ("Formulary" or "Drug List")

Drugs on the Plan's Drug List are selected by Us with the help of a team of doctors and pharmacists. You may call the Member Services Department at the telephone number on Your HNL/Health Net ID Card to find out if a particular drug is on the Formulary or to request a copy of the Formulary. The current Drug List is also available on the HNL website at www.healthnet.com/uc under the pharmacy information.

Prior Authorization

For certain drugs, Your doctor need to obtain a Prior Authorization before We will agree to cover the drug for You. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If You do not get this approval, Your drug might not be covered by the Plan. The Drug List shows which drugs require Prior Authorization.

Urgent requests from Your doctor for Prior Authorization are processed as soon as possible, not to exceed 72 hours, after HNL's receipt of the request and any additional information requested by HNL that is reasonably necessary to make the determination. Routine requests from Your doctor are processed in a timely fashion, not to exceed 5 business days, as appropriate and medically necessary for the nature of Your condition after HNL's receipt of the information reasonably necessary and requested by HNL to make the determination. Requests may be submitted by telephone or facsimile. HNL will evaluate the submitted information upon receiving Your doctor's request for Prior Authorization and make a determination based on established clinical criteria for the particular medication. Your doctor may contact HNL to obtain the usage guidelines for specific medications.

Copayment/Coinsurance Tiers

Every Covered Drug on the Drug List is in one of five (5) Copayment/Coinsurance tiers. In general, the higher the tier, the higher Your cost for the Covered Drug:

- **Tier 1** is the lowest tier and includes preferred Generic Drugs.
- **Tier 2** includes preferred Brand Name Drugs.
- **Tier 3** includes non-preferred Brand Name Drugs.
- **Tier 4** (injectable tier) includes injectable Covered Drugs that do not meet the Centers for Medicare & Medicaid Services (CMS) minimum cost threshold required to be placed on Tier 5 (specialty tier). Some of these Covered Drugs may be limited to a maximum 30-day supply per fill.
- **Tier 5** (specialty tier) is the highest tier and includes high cost Covered Drugs. Some of these Covered Drugs may be limited to a maximum 30-day supply per fill.

To find out which Copayment/Coinsurance tier Your Covered Drug is in, refer to the Plan's Drug List.

Network Pharmacies

We are contracted with many major pharmacy chains, supermarket based pharmacies and privately owned neighborhood pharmacies. To find a conveniently located Network Pharmacy, please visit Our website at www.healthnet.com/uc or call the Member Services Department at the telephone number on Your Health Net ID Card. Present the HNL/Health Net ID Card and pay the appropriate Copayment when the Covered Drug is dispensed.

Some retail Network Pharmacies allow you to get a long-term supply (up to a 90-day supply) of Maintenance Drugs. Some of these retail Network Pharmacies may agree to accept a lower Copayment amount for a long-term supply of Maintenance Drugs. Other retail Network Pharmacies may not agree to accept the lower Copayment amounts for a long-term supply of Maintenance Drugs. In this case you will be responsible for the difference in price.

If You need to have a Prescription Drug Order filled by a Network Pharmacy and have not received Your HNL/Health Net ID Card, or it has been lost, or eligibility cannot be determined, You must pay for the drug(s). You may then be entitled to reimbursement in accordance with the terms of this *Certificate*. After the HNL/Health Net ID Card has been received, You must file a claim. Claim forms will be provided by HNL upon request or may be obtained from the HNL website at www.healthnet.com/uc.

Out-of-Network Pharmacies

Generally, We cover drugs filled at an Out-of-Network Pharmacy **only** when You are not able to use a Network Pharmacy. Here are the circumstances when We would cover prescriptions filled at an Out-of-Network Pharmacy:

- If You are unable to obtain a Covered Drug in a timely manner within our service area because there are no Network Pharmacies within a reasonable driving distance that provide service 24-hours a day, seven days a week.
- If You are trying to fill a Prescription Drug that is not regularly stocked at an accessible retail Network Pharmacy or mail-order pharmacy (including high cost and unique drugs).
- If You are getting a vaccine that is medically necessary but not covered by Medicare Part B, or other Covered Drugs that are administered in Your doctor's office.

- If You need a prescription filled that is related to care for a medical emergency or urgently needed care.
- If You are evacuated or otherwise displaced from Your home because of a federal disaster or other public health emergency declaration.

In these situations, please check first with Member Services Department to see if there is a Network Pharmacy nearby.

If you must use an Out-of-network Pharmacy, You will generally have to pay the full cost (rather than paying Your normal share of the cost) for Your prescription. You may then ask Us to reimburse you for Our share of the cost by filing a claim. Reimbursement will be subject to the terms of this Certificate. Claim forms will be provided by HNL upon request or may be obtained from the HNL website at www.healthnet.com/uc.

Mail Order Program

If Your prescription is for a Maintenance Drug, You can have Your prescription filled through Our mail-order program. Our Plan's mail-order service requires You to order *at least* a 30-day supply of the Covered Drug and *no more than* a 90-day supply.

To get order forms and information about filling Your prescriptions by mail, visit Our website, www.healthnet.com/uc, or call the Member Services Department at the number listed on the back cover of this Certificate of Insurance for assistance. If You use a mail-order pharmacy not in Our network, Your prescription will not be covered.

To use this mail-order program, You must place an order through the mail by completing a Prescription Mail Order Form. It must be accompanied by the original Prescription Drug Order, not a copy. The Prescription Mail Order Form and an explanation of how to use the mail-order program will be provided by HNL upon request. Please contact the Member Services Department at the telephone number on Your ID Card. You may also obtain the Prescription Mail Order Form from the HNL website at www.healthnet.com/uc.

UC Walk-Up Service through UC Medical center Pharmacies

Health Net and the UC Medical Center Pharmacies have partnered to offer UC members with the ability to fill up to a 90-day prescription for maintenance medications at any of the UC designated Medical Center Pharmacies. Just like Health Net's mail-order services, you can obtain up to a 90-day supply at UC-designated Medical Center Pharmacies for the same cost-sharing that you would pay for a 90-day supply from a preferred mail-order pharmacy.

Off-Label Drugs

A Prescription Drug prescribed for a use that is not stated in the indications and usage information published by the manufacturer is covered only if the drug meets all of the following coverage criteria:

1. The drug is approved by the Food and Drug Administration; AND
2. The drug meets one of the following conditions:
 - A. The drug is prescribed by a participating licensed health care professional for the treatment of a life-threatening condition; OR

- B. The drug is prescribed by a participating licensed health care professional for the treatment of a chronic and seriously debilitating condition, the drug is medically necessary to treat such condition and the drug is either on the Formulary or Prior Authorization by HNL has been obtained; AND
3. The drug is recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following:
- A. The American Hospital Formulary Service Drug Information; OR
- B. One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer therapeutic regimen:
- i. The Elsevier Gold Standard's Clinical Pharmacology.
 - ii. The National Comprehensive Cancer Network Drug and Biologics Compendium.
 - iii. The Thomson Micromedex DrugDex; OR
- C. Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

The following definitions apply to the terms mentioned in this provision only.

"Life-threatening" means either or both of the following:

- A. Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted;
- B. Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

"Chronic and seriously debilitating" refers to diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.

GENERAL LIMITATIONS AND EXCLUSIONS

This Plan does not cover the following:

- Drugs that are not listed on Our Drug List, unless they are payable under Your Medicare Part D Prescription Drug plan.
- Drugs that are purchased outside the United States and its territories.
- Drugs dispensed by an Out-of-Network Pharmacy that do not meet the requirements for out-of-network coverage.
- Drugs when used for cosmetic purposes or to promote hair growth.
- Drugs when used to promote fertility.
- Non-prescription drugs (also called over-the-counter drugs).
- Prescription vitamins, mineral products, prenatal vitamins, and fluoride preparations except for drugs listed on the Formulary.

- Drugs when used for treatment of anorexia, weight loss, or weight gain.
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.
- Drugs that the law does not allow any Medicare plans to cover.
- Drugs that are not covered under Your Medicare Part D Prescription Drug plan.
- Lost, Stolen, or Damaged medications.

COORDINATION OF BENEFITS

Benefits provided under this *Certificate* are subject to coordination with benefits payable to You under Your Medicare Part D Prescription Drug coverage through another HNL or Health Net of California, Inc. plan that is sponsored by the Group. The amount We pay for Part D Drugs under this Plan does not count toward Your Medicare Part D initial coverage limit or true out of pocket (TrOOP) costs. However, the amount You pay for Part D Drugs under this Plan does count and will help you move through the different stages of Medicare Part D coverage to qualify for catastrophic coverage for Part D Drugs*. For more information about Medicare Part D Prescription Drug program, please visit the Medicare website at www.medicare.gov.

*Please note that We offer additional coverage on some Prescription Drugs not normally covered in a Medicare Prescription Drug Plan. The amount You pay when You fill a prescription for these drugs does not count towards Your Medicare Part D initial coverage limit or true out of pocket (TrOOP) costs.

GRIEVANCE, APPEALS AND ARBITRATION

Grievance and Appeals Procedures

If you are not satisfied with the efforts to solve a problem related to this Plan with HNL, you must first file a grievance and/or appeal against HNL by calling the Member Services Department at the number on Your HNL/Health Net Identification Card (ID card) or by submitting a Member Grievance Form through the HNL website at www.healthnet.com/uc. You must file Your grievance or appeal with HNL within 365 calendar days following the date of the incident or action that caused Your grievance. You may also file Your complaint in writing by sending information to:

Health Net Life Insurance Company
Appeals and Grievances Department
P.O. Box 10348
Van Nuys, CA 91410-0348]

The grievance and appeal process as it pertains to a claim dispute, is a 15-calendar day process from the date the initial request was received by HNL, until the close of the case with the Covered Person. If a claim-related dispute resolution determination cannot be issued within the initial 15-calendar day period, HNL will still provide the Covered Person with a complete response based on the facts as then known by HNL within the initial 15-calendar day period. All other non-claim disputes are processed within 30 calendar days. Receipt date is defined as the earliest HNL stamp date or practitioner receipt date noted on the document. If any case exceeds the 15-day or 30-day time limit, a letter is sent to the Covered Person by the 15th or 30th calendar day informing him or her of the reason for the pended status.

Arbitration

Sometimes disputes or disagreements may arise between You (including Your enrolled Dependents, heirs or personal representatives) and HNL regarding the construction, interpretation, performance or breach of this Certificate, or regarding other matters relating to or arising out of Your HNL membership. Typically such disputes are handled and resolved through the HNL Grievance, Appeal and Independent Medical Review process described above. However, in the event that a dispute is not resolved in that process, HNL uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as employer groups, health care providers, or their agents or employees, are also involved. In addition, disputes with HNL involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

As a condition to becoming a HNL Covered Person, You agree to submit all disputes You may have with HNL, except those described below, to final and binding arbitration. Likewise, HNL agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both You and HNL are bound to use binding arbitration as the final means of resolving disputes that may arise between the parties, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by HNL's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

HNL's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that the total amount of damages claimed is \$200,000 or less (\$50,000 or less with respect to disputes with HNL involving alleged professional liability or medical malpractice), the parties shall, within 30 days of submission of the demand for arbitration to HNL, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than \$200,000 or \$50,000, whichever is applicable. In the event that total amount of damages is over \$200,000 or \$50,000, whichever is applicable, the parties shall, within 30 days of submission of the demand for arbitration to HNL, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

If the parties fail to reach an agreement during this time frame, then either party may apply to a

Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter. Arbitration can be initiated by submitting a demand for arbitration to HNL at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

Health Net Life Insurance Company
Attention: Litigation Administrator
P.O. Box 4504
Woodland Hills, CA 91356-4505

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this Certificate, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law. The award will be final and binding on all parties except to the extent that state or federal law provide for judicial review of arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees.

Persons who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "adverse benefit determinations" made by HNL to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by HNL to deny, reduce, terminate or not pay for all or a part of a benefit. However, You and HNL may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

MISCELLANEOUS PROVISIONS

Form or Content of the Certificate

No agent or employee of HNL is authorized to change the form or content of this *Certificate*. Any changes can be made only through an endorsement authorized and signed by an officer of HNL.

Benefits Not Transferable

No person other than You is entitled to receive benefits to be furnished by HNL under this Certificate. Such right to benefits is not transferable. Fraudulent use of such benefits will result in cancellation of Your eligibility under this Certificate and appropriate legal action.

Time Limit on Certain Defenses

After this Certificate has been in force for a period of two years, no statements, except fraudulent misstatement, made by the Group contained in the application and no statements relating to insurability made by any Covered Person eligible for coverage under this Certificate can be contested or used to deny any claim.

Notice of Claim

Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any covered loss, or as soon thereafter as reasonably possible. Notice may be given to Us at 21281 Burbank Blvd., Woodland Hills, CA 91367, or to any of Our authorized agents or mailed to Us at P.O. Box 9103, Van Nuys, CA 91409-9103. Notice should include information sufficient for Us to identify the Covered Person.

Claim Forms

When We receive notice of a claim, We will furnish You with Our usual forms for filing proof of loss. If We do not do so within 15 days, You can comply with the requirements for furnishing proof of loss by submitting written proof within the time fixed in this Certificate for filing such proofs of loss. Such written proof must cover the occurrence, the character and the extent of the loss.

Proofs of Loss

Written proof of loss of time on account of disability (where periodic payments depend upon continuing loss), must be given to Us at 21281 Burbank Blvd., Woodland Hills, CA 91367, within 90 days after the end of the period of time for which claim is made; in the case of claim for any other loss, written proof of loss must be furnished within 90 days after the date of the loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if proof is furnished as soon as reasonably possible. Except in the absence of legal capacity, however, We are not required to accept proofs more than one year from the time proof is otherwise required.

Expenses for Copying Medical Records

We will reimburse the Covered Person or provider for reasonable expenses incurred in copying medical records requested by Us.

Time of Payment of Claims

We will pay benefits promptly upon receipt of due written proof of loss.

Payment When You Are Unable To Accept

If a claim is unpaid at the time of Your death or if You are not legally capable of accepting it, it will be paid to Your estate or any relative or person who may legally accept on Your behalf.

Workers' Compensation Insurance

This Certificate is not in lieu of and does not affect any requirement for, or coverage by, Workers' Compensation Insurance.

Member Services Department Interpreter Services

HNL's Member Services Department has bilingual staff and interpreter services for additional languages to handle Covered Person language needs. Examples of interpretive services provided include explaining benefits, filing a grievance and answering questions related to Your health plan in the Covered Person's preferred language. Also, our Member Services staff can help You find a health care provider who speaks Your language. Call the Member Services number on Your Health Net/HNL ID card for this free service. HNL discourages the use of family members and friends as interpreters and strongly discourages the use of minors as interpreters at all medical points of contact where a covered benefit or service is received. Language assistance is available at all medical points of contact where a covered benefit or service is accessed. You do not have to use family members or friends as interpreters. If You cannot locate a health care provider who meets Your language needs, You can request to have an interpreter available at no charge.

Notice

Any notice required of HNL shall be sufficient if mailed to the holder of the Group Policy at the address appearing on the records of HNL. This Certificate, however, will be posted electronically on HNL's website at www.healthnet.com/uc. The Group can opt for the Covered Person to receive this Certificate online. By registering and logging on to HNL's website, Covered Persons can access, download and print this Certificate, or can choose to receive it by U.S. mail, in which case HNL will mail this Certificate to each Covered Person's address on record.

If notice is required of You or the Group, it will be sufficient if mailed to the HNL office at the address listed on the back cover of this Certificate.

Interpretation of Certificate

The laws of the State of California shall be applied to interpretations of this Certificate.

Legal Actions

No action at law or in equity may be brought to recover benefits prior to the expiration of 60 days after written Proof of Loss has been furnished. No such action may be brought after a period of 3 years (or the period required by law, if longer) after the time limits stated in the Proofs of Loss section.

Confidentiality of Medical Records

A STATEMENT DESCRIBING HNL's POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Health Care Plan Fraud

Health care plan fraud is a felony that can be prosecuted. Any person who willfully and knowingly engages in an activity intended to defraud the health care plan by filing a claim that contains a false or deceptive statement is guilty of insurance fraud.

- **Your Responsibility**

As a Covered Person, You must:

1. File accurate claims. If someone else, such as Your spouse who is a Covered Person, files claims on Your behalf, You should review the form before You sign it;
2. Review the explanation of benefits (EOB) form when it is returned to You. Make certain that benefits have been paid correctly based on Your knowledge of the expenses incurred and the services rendered;
3. Never allow another person to obtain Prescription Drug under Your identity. If Your ID card is lost, You should report the loss to Us immediately; and
4. Provide complete and accurate information on claims forms and any other information forms. Attempt to answer all questions to the best of Your knowledge.
5. If You are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if You know of or suspect any illegal activity, call Our toll-free hotline at the number shown on Your HNL/Health Net ID card. All calls are strictly confidential.

Privacy Statement

HNL wants You to understand how We protect Your privacy when We collect and information about Covered Persons, and the measures that We take to safeguard that information. These provisions apply to both current and former Covered Persons, unless We state otherwise.

- **Information Security**

The only individuals who are authorized to have access to nonpublic personal information about Covered Persons ("Covered Person Information") are those individuals who need it to perform their job responsibilities or to provide products or services to Covered Persons. For example, We may access Covered Person Information to offer other compatible

products or services We provide, to process requests We receive from a Covered Person and to administer Our products or services. Our employees are required to maintain the confidentiality of Covered Person Information and to follow the policies and procedures We establish to secure such information. In addition, We maintain physical, electronic and procedural security measures to safeguard Covered Person Information.

- **Information We Collect**

As part of providing Covered Persons with Our services and products, We obtain and collect Covered Person Information about a Covered Person, including:

1. Information We receive from the Covered Person on applications or other forms (such as the Covered Person's name, address, telephone number, social security number, account information, employment, health status and other personal information relevant to the Covered Person's coverage); and
2. Information about the Covered Person's transactions with Us, Our affiliates or others (such as information about premium payment history, Copayments, claims payments, Coinsurance and Deductibles).

Although We collect such information primarily from applications and forms, We may also collect information through other means, such as telephone conversations, web sites and through third parties, such as employers, Physicians, Hospitals and other medical providers. We may also collect such information from Internet "cookies" which may be Used to track web site Usage, remember passwords and provide the Covered Person with web site content specific to the Covered Person's needs and interests.**

- **Disclosures**

We do not disclose any Covered Person Information about a Covered Person or Our former Covered Persons to anyone, except as permitted by law. We may disclose all of the information We collect, as described above in the "Information We Collect" section. For example, Covered Person Information will or may be disclosed for purposes such as to provide services to Covered Persons; to coordinate with reinsurance and excess or stop loss insurers; to enforce a Covered Person's rights; to protect against actual or potential fraud; to resolve Covered Person inquiries or disputes; to carry out Our business; to protect the confidentiality or security of Our records; to administer preventive health and case management programs; to perform underwriting, auditing and ratemaking functions; to enable Our service providers to perform marketing on Our behalf to inform Covered Persons about Our own products or services; to allow Our health insurance affiliate to provide Covered Persons with information about Medicare supplement products; and to comply with federal or state laws and other applicable legal requirements.

- **Additional Information about this Privacy Statement**

The policies indicated in this privacy statement will remain effective, even if the Covered Person's coverage is terminated, to the extent We retain Covered Person Information about the Covered Person. We may change this privacy statement at any time and will inform the Covered Person of any changes as required by law or regulation.

***Information We collect through Our Internet web site is subject to Our Web privacy statement, which is available on Our web site at www.healthnet.com/uc.*

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION AND NONPUBLIC PERSONAL FINANCIAL INFORMATION* ABOUT YOU MAY BE USED AND DISCLOSED. THIS NOTICE ALSO DESCRIBES HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells you about the ways in which Health Net** (referred to as “we” or “the Plan”) may collect, use and disclose Your protected health information and Your rights concerning Your protected health information. “Protected health information” is information about you, including demographic information, that can reasonably be used to identify you and that relates to Your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We are required by federal and state laws to provide you with this Notice about Your rights and our legal duties and privacy practices with respect to Your protected health information. We must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

How We May use and Disclose Your Protected Health Information

We may use and disclose Your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures We may make without Your authorization for payment, health care operations and treatment.

- **Payment.** We use and disclose Your protected health information in order to pay for Your covered health coverage or expenses. For example, We may use Your protected health information to process claims, to be reimbursed by another insurer that may be responsible for payment or for premium billing.
- **Health Care Operations.** We use and disclose Your protected health information in order to perform our plan activities, such as quality assessment activities or administrative activities, including data management or Member Services.
- **Treatment.** We may use and disclose Your protected health information to assist Your health care providers (doctors, pharmacies, hospitals and others) in Your diagnosis and treatment. For example, We may disclose Your protected health information to providers to provide information about alternative treatments.
- **Plan Sponsor.** If you are enrolled through a group health plan, We may provide non-identifiable summaries of claims and expenses for enrollees in Your group health plan to the plan sponsor, which is usually the employer.

If the plan sponsor provides plan administration services, We may also provide access to identifiable health information to support its performance of such services which may include but are not limited to claims audits or Member Services functions. Health Net will only share health information upon a certification from the plan sponsor representing there are restrictions in place to ensure that only plan sponsor employees with a legitimate need to know will have access to health information in order to provide plan administration functions.

We may also disclose protected health information to a person, such as a family member, relative, or close personal friend, who is involved with Your care or payment. We may

disclose the relevant protected health information to these persons if you do not object or We can reasonably infer from the circumstances that you do not object to the disclosure; however, when you are not present or are incapacitated, We can make the disclosure if, in the exercise of professional judgment, We believe the disclosure is in Your best interest.

Other Permitted or Required Disclosures

- **As Required by Law.** We must disclose protected health information about you when required to do so by law.
- **Public Health Activities.** We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.
- **Victims of Abuse, Neglect or Domestic Violence.** We may disclose protected health information to government agencies about abuse, neglect or domestic violence.
- **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g., California Department of Health Services) for activities authorized by law.
- **Judicial and Administrative Proceedings.** We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement.** We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- **Coroners, Funeral Directors, Organ Donation.** We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.
- **Research.** Under certain circumstances, We may disclose protected health information about you for research purposes, provided certain measures have been taken to protect Your privacy.
- **To Avert a Serious Threat to Health or Safety.** We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to Your health and safety or the health and safety of the public or another person.
- **Special Government Functions.** We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- **Workers' Compensation.** We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

Other uses or Disclosures with an Authorization

Other uses or disclosures of Your protected health information will be made only with Your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that We have already taken action on the information disclosed or if We are permitted by law to use the information to contest a claim or coverage under the Plan.

Your Rights Regarding Your Protected Health Information

You have certain rights regarding protected health information that the Plan maintains about you.

- **Right to Access Your Protected Health Information.** You have the right to review or obtain copies of Your protected health information records, with some limited exceptions. usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of Your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing Your requested information, but We will tell you the cost in advance.
- **Right to Amend Your Protected Health Information.** If you feel that protected health information maintained by the Plan is incorrect or incomplete, you may request that We amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny Your request if, for example, you ask Us to amend information that was not created by the Plan, as is often the case for health information in our records, or you ask to amend a record that is already accurate and complete.

If We deny Your request to amend, We will notify you in writing. You then have the right to submit to Us a written statement of disagreement with our decision and We have the right to rebut that statement.

- **Right to an Accounting of Disclosures by the Plan.** You have the right to request an accounting of disclosures We have made of Your protected health information. The list will not include our disclosures related to Your treatment, our payment or health care operations, or disclosures made to you or with Your authorization. The list may also exclude certain other disclosures, such as for national security purposes.

Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, We may charge for providing the accounting, but We will tell you the cost in advance.

- **Right to Request Restrictions on the use and Disclosure of Your Protected Health Information.** You have the right to request that We restrict or limit how We use or disclose Your protected health information for treatment, payment or health care operations. *We may not agree to Your request.* If We do agree, We will comply with Your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In Your request, you must tell Us (1) what information you want to limit; (2) whether you want to limit how We use or disclose Your information, or both; and (3) to whom you want the restrictions to apply.
- **Right to Receive Confidential Communications.** You have the right to request that We use a certain method to communicate with you about the Plan or that We send Plan information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from Us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.
- **Contact Information for Exercising Your Rights.** You may exercise any of the rights described above by contacting our Privacy Office. See the end of this Notice for the contact information.

Health Information Security

Health Net requires its employees to follow the Health Net security policies and procedures that limit access to health information about members to those employees who need it to perform their job responsibilities. In addition, Health Net maintains physical, administrative and technical security measures to safeguard Your protected health information.

Changes to This Notice

We reserve the right to change the terms of this Notice at any time, effective for protected health information that We already have about you as well as any information that We receive in the future. We will provide you with a copy of the new Notice whenever We make a material change to the privacy practices described in this Notice. We also post a copy of our current Notice on our website at www.healthnet.com/uc. Any time We make a material change to this Notice, We will promptly revise and issue the new Notice with the new effective date.

Complaints

If you believe that Your privacy rights have been violated, you may file a complaint with Us and/or with the Secretary of the Department of Health and Human Services. All complaints to the Plan must be made in writing and sent to the Privacy Office listed at the end of this Notice.

We support Your right to protect the privacy of Your protected health information. *We will not retaliate against you or penalize you for filing a complaint.*

**Nonpublic personal financial information includes personally identifiable financial information that you provided to Us to obtain insurance or We obtained in providing benefits to you. Examples include Social Security numbers, account balances and payment history. We do not disclose any nonpublic personal information about you to anyone, except as permitted by law.*

Contact the Plan

If you have any complaints or questions about this Notice or you want to submit a written request to the Plan as required in any of the previous sections of this Notice, please contact:

Address: Health Net Privacy Office
Attention: Director, Information Privacy
P.O. Box 9103
Van Nuys, CA 91409

You may also contact Us at:

Telephone: 1-800-539-4072
Fax: 1-818-676-8314
Email: Privacy@healthnet.com

DEFINITIONS

This section defines words that will help You understand Your Plan. These words appear throughout this Certificate with the initial letter of the word in capital letters.

Average Wholesale Price is the amount listed in a national pharmaceutical pricing publication, and accepted as the standard price for a Prescription Drug.]

Brand Name Drug is a Prescription Drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand Name Drugs have the same active-ingredient formula as the generic version of the Brand Name Drug. However, Generic Drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the Brand Name Drug has expired.

Calendar Year is the twelve-month period that begins at 12:01 a.m. Pacific Time on January 1 of each year.

Calendar Year Deductible is the amount of outpatient Prescription Drug Covered Expenses which must be incurred by You each Calendar Year and for which You have payment responsibility before benefits become payable by HNL.

Coinsurance is the percentage of the Covered Expenses for which You are responsible, as specified in the "Schedule of Benefits" section.

Commercial Pharmacy Wrap Plan (also known as “Wrap” or “Wrap Plan”) is the plan that is described in this Certificate, which coordinates benefits with Your Medicare Part D Prescription Drug coverage that is provided through another HNL or Health Net plan offered by Your Group.

Copayment is a fixed dollar fee charged to You for Covered Services and Supplies when You receive them. The amount of each Copayment is indicated in the "Schedule of Benefits" section

Covered Person is the enrolled employee/retiree (referred to as "You" or "Your" or the "principal Covered Person") or his or her Dependent who is covered under this Certificate.

Covered Drugs is the term We use to mean all of the Prescription Drugs covered by our Plan.

Deductible is the amount You must pay for Covered Drugs before We begin to pay Our share of the Covered Drugs.

Dependent is (a) the Certificateholder's spouse, or registered Domestic Partner, who is covered under Medicare.

Domestic Partner is a person eligible for coverage provided that the partnership with the principal Covered Person meets all domestic partnership requirements under California law or other recognized state or local agency.

- The Domestic Partner and principal Covered Person must:
- Have a common residence. It is not necessary that the legal right to possess the common residence be in both names.
- Not be married or a member of another domestic partnership with someone else that has not been terminated, dissolved or judged a nullity.

- Not be related by blood in a way that would prevent them from being married to each other in this state.
- Be at least 18 years of age.
- Be capable of consenting to the domestic partnership.
- Be either of the following:
 - Members of the same sex; or
 - Members of the opposite sex and one or both be eligible for Social Security benefits and one or both be over the age of 62.
- Both file a Declaration of Domestic Partnership with the Secretary of State or an equivalent document with another recognized state or local agency, or both are persons of the same sex who have validly formed a legal union other than marriage in a jurisdiction outside of California which is substantially equivalent to a Domestic Partnership as defined under California law.

(The requirements listed above are statutory eligibility requirements. Your Group's Domestic Partner eligibility requirements may be less restrictive.)

Drug List (also known as "Formulary") is a list of the Prescription Drugs that are covered by this Plan. It is prepared and updated by HNL and distributed to Covered Persons, doctors who have a contract with Us, and Network Pharmacies and posted on the HNL website at www.healthnet.com/uc under the pharmacy information. Some Drugs in the Drug List require Prior Authorization from HNL in order to be covered.

Effective Date is the date on which You become covered or entitled to benefits under this Certificate.

Generic Drug is a Prescription Drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the Brand Name Drug. Generally, Generic Drugs cost less than Brand Name Drugs.

Group is the business organization (usually an employer or trust) to which HNL has issued the Policy to provide the benefits of this Plan.

Health Net Life Insurance Company (HNL) is a life and disability insurance company domiciled in California. The term "We," "Our," or "Us" when they appear in this Certificate refer to HNL.

Maintenance Drugs are Prescription Drugs taken continuously to manage chronic or long-term conditions where Covered Persons respond positively to a drug treatment plan with a specific medication at a constant dosage requirement.

Maximum Allowable Cost is the maximum charge We will allow for Generic Drugs or for Brand Name Drugs which have a generic equivalent. A list of Maximum Allowable Costs is maintained, and may be revised periodically, by Us.

Medicare Part D is the Medicare prescription drug program which is the insurance to help pay

for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B. For more information about Medicare Part D, please visit the Medicare website at www.medicare.gov.

Network Pharmacy is a pharmacy where You can get Your Prescription Drug benefits. We call them “Network Pharmacies” because they contract with Our plan. In most cases, Your prescriptions are covered only if they are filled at one of our Network Pharmacies.

Out-of-Network Pharmacy is a pharmacy that does not have a contract with Our plan to coordinate or provide You with Covered Drugs. As explained in this *Certificate*, most drugs You get from Out-of-Network Pharmacies are not covered by this Plan unless certain conditions apply.

Part D Drugs are drugs that can be covered under Medicare Part D. We may or may not offer all Part D drugs. (See Your Formulary for a specific list of Covered Drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D Drugs.

Prescription Drug is a drug or medicine that can be obtained only by a Prescription Drug Order. All Prescription Drugs are required to be labeled "Caution, Federal Law Prohibits Dispensing Without a Prescription." An exception is insulin and other diabetic supplies, which are considered to be Covered Drugs.

Prescription Drug Covered Expenses are the maximum charges We will allow for each Prescription Drug Order. The amount of Prescription Drug Covered Expenses varies by whether a Network Pharmacy or an Out-of-Network Pharmacy dispenses the order. It is not necessarily the amount the pharmacy will bill. Any expense incurred which exceeds the following amounts is not a Prescription Drug Covered Expense: (a) for Prescription Drug Orders dispensed from a Network Pharmacy, or through the mail-order program, the Prescription Drug Allowable Charge; (b) for Prescription Drug Orders dispensed by an Out-of-Network Pharmacy, the lesser of the Maximum Allowable Cost or the Average Wholesale Price.

Prescription Drug Allowable Charge is the charge that Network Pharmacies and the mail-order program have agreed to charge Covered Persons, based on a contract between HNL and such provider.

Prescription Drug Order is a written or verbal order or refill notice for a specific drug, strength and dosage form (such as a tablet, liquid, syrup or capsule) directly related to the treatment of an illness or injury and which is issued by the attending physician within the scope of his or her professional license.

Prior Authorization is an approval in advance to get certain drugs that may or may not be on Our Drug List. Some drugs are covered only if Your doctor or other network provider gets “Prior Authorization” from Us. Covered Drugs that need prior authorization are marked on the Drug List.

NOTICE OF LANGUAGE SERVICES

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number on your ID card. For Individual and Family or Farm Bureau members please call 800-839-2172. Employer group members please call 800-522-0088. PPO members: for more help call the CA Dept. of Insurance at 1-800-927-4357. HMO members: for more help call the Department of Managed Health Care HMO Help Line at 1-888-HMO-2219. **English**

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que una persona le lea los documentos y que algunos se envíen en su idioma. Para solicitar ayuda, llámenos al número que aparece en su tarjeta de identificación. Para los afiliados de Individual y Familiar o de la Oficina Agrícola, llame al número 800-839-2172. Los afiliados de un grupo del empleador deben llamar al 800-522-0088. Afiliados de PPO: para obtener más ayuda llame al Departamento de Seguros de CA al 1-800-927-4357. Afiliados de HMO: para obtener más ayuda llame a la Línea de Ayuda del Departamento de Cuidado Médico de HMO al 1-888-HMO-2219. **Spanish**

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，部分文件可以翻譯成您的語言並寄遞給您。欲取得協助，請撥打您會員卡上的電話號碼與我們聯絡。個人與家庭計畫或農業協會的會員請撥打 800-839-2172。僱主團體會員請撥打 800-522-0088。PPO 會員：欲取得更多協助，請致電加州保險局 1-800-927-4357。HMO 會員：欲取得更多協助，請致電醫療保健計畫管理局 HMO 協助專線 1-888-HMO-2219。 **Chinese**

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, xin gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị. Các hội viên Individual and Family hoặc Farm Bureau có thể gọi số 800-839-2172. Các hội viên trong chương trình bảo hiểm theo nhóm của hãng sở xin gọi số 800-522-0088. Các hội viên PPO: để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Các hội viên HMO: để được giúp đỡ thêm, xin gọi Đường Dậy Trợ Giúp HMO của Sở Điều Quản Y Tế tại số 1-888-HMO-2219. **Vietnamese**

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다. 도움이 필요하신 경우, 본인 ID 카드 상의 안내번호로 전화해 주십시오. 개인 및 가족 회원 혹은 Farm Bureau 회원께서는 800-839-2172번으로 전화해 주십시오. 고용주 그룹 회원께서는 800-522-0088번으로 전화해 주십시오. PPO 가입자: 보다 많은 도움이 필요하신 분은 캘리포니아 보험 담당국, 안내번호 1-800-927-4357번으로 문의하십시오. HMO 가입자: 보다 많은 도움이 필요하신 분은 보건관리부 (the Department of Managed Health Care)의 HMO 헬프라인, 안내번호 1-888-HMO-2219번으로 문의하십시오. **Korean**

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card. Para sa Individual at Family members, mangyaring tumawag sa 800-839-2172. Para sa employer group members, mangyaring tumawag sa 800-522-0088. Para sa PPO members: para sa karagandang tulong, tumawag sa CA Dept. of Insurance sa 1-800-927-4357. Para sa HMO members: para sa karagandang tulong, tumawag sa Department of Managed Health Care HMO Help Line sa 1-888-HMO-2219. **Tagalog**

Ազատ Երկար լեզվալեզու և ծանուցումներ: Գործարարները կարող են ստանալ օգնություն և փաստաթղթերը ընթերցել սույլ մեր լեզվով: Օգնություն ստանալ, մեզ զանգահարեք մեր ինքնուրույն տոմսի վրա նշված համարով: Եթե անհամար կամ անհամար կան և ընտանեկան կամ Ագրարական Գյուղատնտեսական (Farm Bureau), զանգահարեք 800-839-2172 համարով: Գործատիրոջ կողմից անհամարները խնդրվում է զանգահարել 800-522-0088 համարով: PPO-ի անդամները լրացուցիչ տեղեկություններ ստանալ 1-800-927-4357 համարով զանգահարել կամ Կալիֆոռնիայի Առողջապահության և Բնագործության Բաժնից: HMO-ի անդամները լրացուցիչ տեղեկություններ ստանալ 1-888-HMO-2219 համարով զանգահարել կամ Առողջապահության և Բնագործության Գծից: **Armenian**

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочесть документы на вашем языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте; участники планов индивидуального или семейного страхования, а также плательщики страховых взносов Фермерского бюро могут позвонить по телефону 800-839-2172. Участники плана группового страхования по месту работы могут позвонить по телефону 800-522-0088. Участники системы предпочтительного выбора (Preferred Provider Organization, PPO): для получения дополнительной помощи звоните в Министерство здравоохранения штата Калифорния по телефону 1-800-927-4357. Участники организационной медицинской обслуживания (Health Maintenance Organizations, HMO): для получения дополнительной помощи звоните в справочную службу ПМО Департамента организованного медицинского обслуживания по телефону 1-888-HMO-2219. **Russian**

無料の言語サービス。日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号までお問い合わせください。個人、家族会員、または、ファーム・ビューロー会員の方は、800-839-2172 まで、雇用者団体会員の方は、800-522-0088 までご連絡ください。PPO 会員の方：更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357 までご連絡ください。HMO 会員の方：更なるお問い合わせは、カリフォルニア州管理医療庁のHMO相談窓口、1-888-466-2219 までご連絡ください。 **Japanese**

خدمات مجاني مربوط به زبان. میتونید از خدمات یک مترجم شفاهی برخوردار بشید و بگوشه مدارک به زبان خودتون برایش خوانده بشوند. برای دریافت کمک، ما ما از طریق شماره تلفنی که روی کارت شناسایی شما قید شده است تماس بگیریم. اعضای طرح افراد و خانواده ها، یا «طرح اداره مراکز» لطفاً به شماره 800-839-2172 تلفن کنید. اعضای گروه های کشاورزی لطفاً به شماره 800-522-0088 تماس بگیریم. اعضای PPO: برای کمک بیشتر لطفاً با اداره بیمه کالیفرنیا به شماره 800-927-4357 تماس بگیرید. اعضای HMO: برای کمک اطلاعات بیشتر به خط کمک HMO در Department of Managed Health Care به شماره 1-888-HMO-2219 تلفن کنید. **Farsi**

ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਬਾਰੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਜਾਂ ਫਾਰਮ ਮੈਂਬਰਾਂ ਨੂੰ ਮੈਂਬਰ ਕਾਰਡ 800-839-2172 ਨੰਬਰ 'ਤੇ ਫੋਨ ਕਰੋ। ਇੰਸੂਰੈਂਸ ਗਰੁੱਪ ਦੇ ਮੈਂਬਰ ਕਾਰਡ 800-522-0088 ਨੰਬਰ 'ਤੇ ਫੋਨ ਕਰੋ। PPO ਮੈਂਬਰ: ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ ਇਨਸੂਰੈਂਸ ਨੂੰ 1-800-927-4357 ਨੰਬਰ 'ਤੇ ਫੋਨ ਕਰੋ। HMO ਮੈਂਬਰ: ਵਧੇਰੇ ਮਦਦ ਲਈ ਡਿਪਾਰਟਮੈਂਟ ਆਫ ਮੈਨੇਜਡ ਹੈਲਥ ਕੇਅਰ ਦੀ HMO ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ 'ਤੇ ਫੋਨ ਕਰੋ। **Punjabi**

ការកែប្រែភាសាដើមឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកកែប្រែភាសា និងព័ត៌មានអំពីការទទួលបានសេវាភាសាខ្មែរ។ សំណុំជំនួយ សូមអ្នកស្នើសុំអតិថិជន តាមលេខទូរស័ព្ទ 800-522-0088 ។ សំណុំសមាជិក ផ្សេងៗទៀត និងក្រសួង ឬសមាជិក Farm Bureau សូមអ្នកស្នើសុំអតិថិជន 800-839-2172 ។ សមាជិកក្រុមប្រឹក្សាស្រូវស្រែប្រាំង 800-522-0088 ។ សមាជិក PPO: សំណុំជំនួយជំនួយ សូមអ្នកស្នើសុំអតិថិជន តាមលេខ 1-800-927-4357 ។ សមាជិក HMO: សំណុំជំនួយជំនួយ សូមអ្នកស្នើសុំអតិថិជន តាមលេខ 1-888-HMO-2219 ។ **Khmer**

خدمات ترجمه بدون تکلیف. می‌توانید از خدمات یک مترجم شفاهی برخوردار بشید و بگوشه مدارک به زبان خودتون برایش خوانده بشوند. برای دریافت کمک، ما ما از طریق شماره تلفنی که روی کارت شناسایی شما قید شده است تماس بگیریم. اعضای طرح افراد و خانواده ها، یا «طرح اداره مراکز» لطفاً به شماره 800-839-2172 تلفن کنید. اعضای گروه های کشاورزی لطفاً به شماره 800-522-0088 تماس بگیریم. اعضای PPO: برای کمک بیشتر لطفاً با اداره بیمه کالیفرنیا به شماره 800-927-4357 تماس بگیرید. اعضای HMO: برای کمک اطلاعات بیشتر به خط کمک HMO در Department of Managed Health Care به شماره 1-888-HMO-2219 تلفن کنید. **Arabic**

Cov Kev Pab Txhais Lus Ulas Tsis Tau Them Nqi. Koj kom muaj ib tug neeg txhais lus rau koj los tau. Koj kom nyeem cov ntauw ntauw thiab xa ib co ntauw ntauw ua koj hom lus tuaj rau koj los tau. Yog xav tau kev pab, hu rau pcb ntauw tus xov toj nyob hauv koj dam yuaj ID. Rau cov tsaw cuab hauv pawg Tus Khej thiab Tsev Neeg los sis Farm Bureau thov hu rau 800-839-2172. Cov tsaw cuab hauv pawg tom chaw ua hauv lwj thov hu rau 800-522-0088. Cov tsaw cuab hauv PPO: yog xav tau kev pab ntawv hu rau CA Lub Koom Hauv Saib Xyuas Txog Kev Tuav Pov Hwm ntauw 1-800-927-4357. Cov tsaw cuab hauv HMO: yog xav tau kev pab ntawv hu rau Lub Caj Mecm Fai Saib Xyuas Txog Kev Tswj Txoj Kev Kho Mob (Department of Managed Health Care) HMO Tus Xov Tooj Muab Kev Pab ntauw 1-888-HMO-2219. **Hmong**

ບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດໄດ້ຮັບບໍລິການແປພາສາແລະມີຕູ້ອ່ານເອກກະສານໃຫ້ທ່ານຟັງເປັນພາສາຂອງທ່ານເອງ. ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມພາຍເລກທີ່ລະບຸໃນບັດປະກັນໄພຂອງທ່ານ. ຂໍໃຫ້ສະມາຊິກລາຍບູກຄົນແລະຄອບຄົວຫລືສະມາຊິກ Farm Bureau ໂທຕາມພາຍເລກ 800-839-2172. ຂໍໃຫ້ສະມາຊິກກຸ່ມລູກຈາງໂທຕາມພາຍເລກ 800-522-0088. ສະມາຊິກ PPO: ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອເພີ່ມຕື່ມ ໃຫ້ໂທໂທທາງກົມປະກັນໄພແຫ່ງລັດຄາລິຟໍເນຍຕາມພາຍເລກ 1-800-927-4357. ສະມາຊິກ HMO: ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອເພີ່ມຕື່ມ ໃຫ້ໂທຕາມສາຍດ່ວນ HMO ແຫ່ງກົມກຳກັບລະບົບຄຸມຄອງການຮັກສາສຸຂະພາບ (Department of Managed Health Care) ຕາມພາຍເລກ 1-888-HMO-2219. **Laotian**

Health Net Life
Commercial Pharmacy Wrap Plan
P.O. Box 10348
Van Nuys, CA 91049

Member Services Department

1.800.593.4072

Our office hours are from 8:00 a.m. to 8:00 p.m., 7 days a week.

Telecommunications Device for the Hearing and Speech impaired

1.800.929.9955

Our office hours are from 8:00 a.m. to 8:00 p.m., 7 days a week.

Para los que hablan español

1.800.806.8811

Nuestras horas de negocio son de las de 8:00am a 8:00pm, siete días a la semana.

Dispositivo de telecomunicaciones para las personas con impedimentos auditivos

1.800.929.9955

Nuestras horas de negocio son de las de 8:00am a 8:00pm, siete días a la semana.

WWW.HEALTHNET.COM/UC