



Health and Wellness Benefit Election Form

Date: _____

Member Name: _____

(Please Print First and Last Name)

Member Birth Date: _____

(Month/Day/Year)

PHC California members may choose a gym membership from 24 Hour Fitness **or** up to \$200 a calendar year of over-the-counter (OTC) pharmacy items. Please make your choice below. You may only choose one option.

24 Hour Fitness gym membership

Membership good at any 24 Hour Fitness, except 24 Hour Fitness Ultra Sport locations.

Over-the-counter (OTC) pharmacy items

Limited to \$200 per calendar year. Members who choose the OTC option will order from a list of items like vitamins, fiber supplements, first aid supplies, sunscreen, tooth brushes and pastes, cold medication, antacids, etc. Members will get order forms with instructions from the plan. Members may place orders for items through the year up to the annual limit of \$200. Order forms with instructions are also available at www.phc-ca.org/members/otc.

Decline the Health and Wellness Benefit

Declining the benefit will not affect your eligibility for PHC California. It won't affect your membership in PHC California. If you decline the benefit, you may change your decision anytime. Please call Member Services if you want to activate the benefit. Call (800) 263-0067 (TTY 711), Monday through Friday, 8:00 am to 8:00 pm

Please read below and initial by each statement to indicate you have read and understand the terms of the program.

_____ I understand that I may choose only one benefit option during the calendar year (January 1 through December 31).

_____ I understand that I may only change my Health and Wellness Benefit option choice once a calendar year from January 1 through January 15.

_____ I understand that it may take 15 to 45 days for the processing of my Health and Wellness Benefit option choice.

_____ I understand that PHC California will contact me by mail with instructions or forms to activate the option I choose.

_____ I understand that the Health and Wellness Benefit option that I choose is only valid for me. It can only be used by me.

_____ I understand that if I choose the gym membership option and I leave the plan, my gym membership will end on the same day as my disenrollment effective date.

Member Signature: _____

Address: _____

(Street Address, City, State, Zip)

Home Phone: _____ Alternate Phone: _____

Discrimination Is Against the Law

PHC California complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PHC California does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PHC California:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need access to these services, please contact Member Services at (800) 263-0067.

If you believe that PHC California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Member Services, P.O. Box 46160, Los Angeles, CA 90046, (800) 263-0067, TTY 711, Fax (888) 235-8552, email php@positivehealthcare.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-263-0067 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-263-0067 (TTY: 711)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-263-0067 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-263-0067 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-263-0067 (TTY: 711) 번으로 전화해 주십시오.

ՈՒՇԱԴՐՈՒԹՅՈՒՆՆԵՐ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Ձանգահարեք 1-800-263-0067 (TTY (հեռատիպ)՝ 711):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-263-0067 (TTY: 711) تماس بگیرید.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-263-0067 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-263-0067 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-263-0067 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-263-0067 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតល្អលក្ខណ៍គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-263-0067 (TTY: 711)។

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-263-0067 (TTY: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-263-0067 (TTY: 711) पर कॉल करें।

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-263-0067 (TTY: 711).