Enrollment Application and Membership Agreement: Individual/Family

Mail your completed application to: Western Health Advantage/Individual Sales
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Fax to: 916.568.1338

Note: Use this form to apply for a Western Health Advantage (WHA) Individual/Family Plan. Please answer all questions completely. You should sign this application only if you understand each question and agree to the response provided, even if a broker assists you with the application. If you have questions about completing this application, please call 916.563.2250. We will provide translation services and other language assistance free of charge if you need it. Or, if you are working with a broker, please call him or her for assistance.

PERSON APPLYING FOR COVERAGE ("APPLICANT")

First Name_____ MI ____ Last Name _____

Social Security Number _____ Date of Birth _____

Residential Street Address _____ Apt./Unit#_____

City, State, Zip _____ County _____

Mailing Address _____ Apt./Unit#_____

City, State, Zip _____

Primary Phone _____ Secondary Phone _____

Email Address_____ Existing Patient ❑ Yes ❑ No

Primary Care Physician _____ ID# _____ Medical Group _____

Gender* ❑ Male ❑ Female ❑ Intersex

Are you of Latino, Hispanic or Spanish origin? ❑ Decline to State ❑ Yes ❑ No

How would you describe your race? Check all that apply ❑ Decline to State ❑ White/Caucasian
❑ American Indian/Alaska Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Pacific Islander
❑ Other _____

What language do you feel most comfortable speaking? ❑ Decline to State ❑ English ❑ Spanish
❑ Other _____

What language do you prefer for written materials? ❑ Decline to State ❑ English ❑ Spanish
❑ Other _____

*In order to serve you better, please visit the WHA secure member portal, mywha.org, to indicate your preferred pronouns, sexual orientation and gender identity.

DEPENDENT INFORMATION ❑ Add ❑ Remove | Gender* ❑ Male ❑ Female ❑ Intersex

Relationship to Subscriber ❑ Spouse/Domestic Partner ❑ Child, up to age 26 ❑ Parent/Stepparent**

Social Security Number _____ Date of Birth _____

First Name_____ MI ____ Last Name _____

Primary Care Physician _____ ID# _____

Medical Group _____ Existing Patient ❑ Yes ❑ No

Are you of Latino, Hispanic or Spanish origin? ❑ Decline to State ❑ Yes ❑ No

How would you describe your race? Check all that apply ❑ Decline to State ❑ White/Caucasian

❑ American Indian/Alaska Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Pacific Islander

❑ Other _____

What language do you feel most comfortable speaking? ❑ Decline to State ❑ English ❑ Spanish

❑ Other _____

What language do you prefer for written materials? ❑ Decline to State ❑ English ❑ Spanish

❑ Other _____

DEPENDENT INFORMATION ❑ Add ❑ Remove | Gender* ❑ Male ❑ Female ❑ Intersex

Relationship to Subscriber ❑ Spouse/Domestic Partner ❑ Child, up to age 26 ❑ Parent/Stepparent**

Social Security Number _____ Date of Birth _____

First Name_____ MI ____ Last Name _____

Primary Care Physician _____ ID# _____

Medical Group _____ Existing Patient ❑ Yes ❑ No

Are you of Latino, Hispanic or Spanish origin? ❑ Decline to State ❑ Yes ❑ No

How would you describe your race? Check all that apply ❑ Decline to State ❑ White/Caucasian

❑ American Indian/Alaska Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Pacific Islander

❑ Other _____

What language do you feel most comfortable speaking? ❑ Decline to State ❑ English ❑ Spanish

❑ Other _____

What language do you prefer for written materials? ❑ Decline to State ❑ English ❑ Spanish

❑ Other _____

**For additional information concerning covered benefits for a dependent parent or stepparent who is eligible for or enrolled in Medicare, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. HICAP provides health insurance counseling for California senior citizens. Call the HICAP toll-free telephone number, 1.800.434.0222, for a referral to your local HICAP office, or see the listing provided below. HICAP is a service provided free of charge by the State of California.

El Dorado, Placer, Sacramento, and Yolo Counties
Address: 505 12th Street, Sacramento, CA 95814 Telephone: 916.376-8915 (Monday – Friday: 9 a.m. – 4 p.m.)

Marin, Napa, Solano, and Sonoma Counties
Address: 1129 Industrial Ave, Suite 201, Petaluma, CA 94954 Telephone: 707.526.4108 (Monday – Friday: 9 a.m. – 3 p.m.)

DEPENDENT INFORMATION ❑ Add ❑ Remove | Gender* ❑ Male ❑ Female ❑ Intersex

Relationship to Subscriber ❑ Spouse/Domestic Partner ❑ Child, up to age 26 ❑ Parent/Stepparent**

Social Security Number _____ Date of Birth _____

First Name_____ MI ____ Last Name _____

Primary Care Physician _____ ID# _____

Medical Group _____ Existing Patient ❑ Yes ❑ No

Are you of Latino, Hispanic or Spanish origin? ❑ Decline to State ❑ Yes ❑ No

How would you describe your race? Check all that apply ❑ Decline to State ❑ White/Caucasian

❑ American Indian/Alaska Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Pacific Islander

❑ Other _____

What language do you feel most comfortable speaking? ❑ Decline to State ❑ English ❑ Spanish

❑ Other _____

What language do you prefer for written materials? ❑ Decline to State ❑ English ❑ Spanish

❑ Other _____

DEPENDENT INFORMATION ❑ Add ❑ Remove | Gender* ❑ Male ❑ Female ❑ Intersex

Relationship to Subscriber ❑ Spouse/Domestic Partner ❑ Child, up to age 26 ❑ Parent/Stepparent**

Social Security Number _____ Date of Birth _____

First Name_____ MI ____ Last Name _____

Primary Care Physician _____ ID# _____

Medical Group _____ Existing Patient ❑ Yes ❑ No

Are you of Latino, Hispanic or Spanish origin? ❑ Decline to State ❑ Yes ❑ No

How would you describe your race? Check all that apply ❑ Decline to State ❑ White/Caucasian

❑ American Indian/Alaska Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Pacific Islander

❑ Other _____

What language do you feel most comfortable speaking? ❑ Decline to State ❑ English ❑ Spanish

❑ Other _____

What language do you prefer for written materials? ❑ Decline to State ❑ English ❑ Spanish

❑ Other _____

**For additional information concerning covered benefits for a dependent parent or stepparent who is eligible for or enrolled in Medicare, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. HICAP provides health insurance counseling for California senior citizens. Call the HICAP toll-free telephone number, 1.800.434.0222, for a referral to your local HICAP office, or see the listing provided below. HICAP is a service provided free of charge by the State of California.

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Marin, Napa, Solano, and Sonoma Counties
Address: 1129 Industrial Ave, Suite 201, Petaluma, CA 94954 Telephone: 707.526.4108 (Monday – Friday: 9 a.m. – 3 p.m.)

PERSON RESPONSIBLE ❑ Check if same as applicant

Relationship to Subscriber _____

First Name_____ MI ____ Last Name_____

Address _____ Apt./Unit#_____

City, State, Zip _____

Home Phone_____❑ Day ❑ Evening Work Phone _____❑ Day ❑ Evening

Preferred Spoken Language ❑ English ❑ Spanish ❑ Russian ❑ Chinese ❑ Vietnamese ❑ Other _____

CORRESPONDENCE AND BILLING INFORMATION

Send all correspondence to: ❑ Applicant ❑ Person Responsible

Send billing to: ❑ Applicant ❑ Person Responsible ❑ Third Party (provide information below)

Third Party Administrator (TPA) Name_____

Billing Address _____ Apt./Unit#_____

City, State, Zip _____

Application must be accompanied by a check for the first month's premium.

Once enrolled the following options are available for paying your monthly premium:

- Check including eCheck
- Electronic funds transfer (EFT)
- Visa, Mastercard, American Express or Discover

PLAN INFORMATION

1. Which health plan would you like to enroll in? (Select only one plan.)

❑ WHA Platinum 90 HMO ❑ WHA Gold 80 HMO ❑ WHA Off Exchange Silver 70 HMO

❑ WHA Bronze 60 HMO ❑ WHA Bronze 60 HDHP HMO** ❑ WHA Minimum Coverage HMO*

❑ Advantage WHA Silver 4800 HDHP HMO** ❑ Advantage WHA Bronze 7000 HDHP HMO**

* Enrollment limited to those age 30 and under OR qualified exemptions

** If you are electing the HSA-compatible plan and wish to open a Health Savings Account, be sure to complete an HSA Authorization Form.

2. WHA offers DeltaCare® USA, an adult dental rider, to Individual/Family plans. Note: The adult dental rider is added to all adult members (19 or older) covered on the selected plan.

❑ I elect to add the DeltaCare® USA to my plan. I understand that I will see an additional charge of $18.57 per month per adult member on my premium billing statement.

3. Effective Date, I request to be enrolled with an effective date of:

❑ 1st of the month following this month (Your application must be received by the 15th of the current month.)

❑ 1st of the month following next month (Your application must be received by the 15th of next month.)

WHA will make every effort to honor your requested effective date. However, if processing is not complete by your requested effective date, you will be enrolled, effective the 1st of the month following approval.

SPECIAL ENROLLMENT PERIOD

The annual Open Enrollment period for new coverage is November 1 through January 31. These dates are subject to change pursuant to changes in the law. You may change your benefit plan, sign up for health care coverage or add eligible dependents during the Open Enrollment period.

Outside of this Open Enrollment period, you can only sign up for health care, change your coverage or add eligible dependents if you have experienced a qualifying life event. This is called a Special Enrollment Period. You must enroll within 60 days of the qualifying event in order to be eligible for a Special Enrollment Period. If 60 days pass and you do not sign up for health coverage, you will have to wait until the next open enrollment period.

WHA reserves the right to ask for verification of the qualifying event.

I attest that I am or my dependents are eligible to enroll under a Special Enrollment Period due to the following qualifying event:

LOSS OF COVERAGE

- ❑ Loss of employer health coverage due to job loss
- ❑ Employer coverage changed such as a reduction in hours worked
- ❑ COBRA coverage ended
- ❑ Loss of Medi-Cal or Medicaid coverage
- ❑ End of military service

FAMILY AND AGE CHANGES

- ❑ Turning 26 years old and no longer eligible as a dependent on your parent's plan
- ❑ Getting married
- ❑ Birth of a child or recent adoption
- ❑ Divorce or legal separation from the person through whom you were covered as a dependent
- ❑ Death of the person through whom you were covered as a dependent
- ❑ Court ordered coverage for your dependent

OTHER

- ❑ Permanent Relocation
- ❑ Moved outside the service area of your existing health insurance carrier
- ❑ Moved within California with access to new plans
- ❑ Other_____

NOTE: Qualifying Events are established by state and federal law. WHA will enroll applicants consistent with the law, and this list will be deemed amended following any change to relevant laws.

CONDITIONS OF ACCEPTANCE

Please read the following information and sign in the space(s) provided on the following page. **Please read this section carefully. This section contains important information, including the reasons WHA may terminate or rescind coverage.**

You must fully answer each question in this application even though you may already be a WHA member.

Be sure to complete the Application/Agreement accurately. If you are unsure about the answer to any question, take the time to make sure the information is accurate before submitting your Application/Agreement. By signing this Application/Agreement, you represent that all responses are true, complete, and accurate to the best of your knowledge, and that if WHA accepts your application for coverage, the Application/Agreement, together with the Combined Evidence of Coverage and Disclosure Form (EOC/DF), will constitute the plan contract between you and WHA. If WHA accepts the Applicant or Dependent(s) for coverage, coverage will begin on the first of the month following acceptance, or the first of the following month, based on your selection under "Effective Date" in this Application/Agreement. Your Application/Agreement is effective through December 31. If you comply with all the terms of this Application/Agreement and the EOC/DF, WHA will automatically renew this Application/Agreement each year on January 1. Terms of the Application/Agreement and the EOC/DF will remain the same when we renew it unless WHA has amended the documents as described under "Amendment of Agreement" in the EOC/DF.

Upon acceptance, you will be provided with an EOC/DF. By accepting benefits under a WHA Individual/Family Plan, you agree to be bound by the Application/Agreement and by the EOC/DF. The EOC/DF for the Individual Advantage Plans is available upon request from WHA or your broker prior to enrollment.

WHA may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this agreement. You may not assign this agreement or any of the rights, interests, claims for money due, benefits, or obligations hereunder without WHA's prior written consent. In any dispute between you and WHA, a medical group or any participating provider, each party will bear its own attorneys' fees and other expenses. WHA's failure to enforce any provision of this Application/Agreement, or of the EOC/DF, will not constitute a waiver of that or any other provision, or impair WHA's right thereafter to require your strict performance of any provision.

If covered by a WHA Individual/Family Plan, in the event you suffer injury, illness or death due to the act or omission of a third party, WHA will furnish Covered Services. In the event any recovery is obtained on your behalf, you or your representative must reimburse WHA for the value of Covered Services as set forth in the EOC/DF. By executing this Application/Agreement, you grant on your behalf and on Applicant's behalf, a lien on any such recovery and agree to cooperate with WHA when there is any possibility that a recovery may be received.

The Applicant and dependents must live within WHA's Service Area. You may contact your broker or WHA to determine whether the Applicant lives within WHA's Service Area, or you may view the Service Area Map on WHA's website. When the Applicant is enrolled for coverage and at any time no longer lives within the Service Area, the Applicant is no longer eligible for coverage. When the Dependent is enrolled for coverage and at any time no longer lives within the Service Area, the Dependent is no longer eligible for coverage. Living outside the Service Area is a material fact that must be reported to WHA.

If WHA accepts your application for coverage, that coverage may be terminated for fraud or intentional misrepresentation of a material fact, including but not limited to fraud or material misrepresentation or omission in providing or failing to provide material information to WHA, the use of the services of the plan, or for knowingly permitting such fraud or material misrepresentation or omission by another. Such termination shall be effective upon the mailing of written notice by WHA to you. WHA may terminate an individual's coverage only if allowed (or not disallowed) by federal and state laws and regulations.

Before making any decision to rescind, WHA would notify you in writing of the grounds for rescission. WHA's notice will tell you why your application is believed to be inaccurate or incomplete and will invite you to provide WHA with additional information. If, after considering your response, WHA decides to rescind, WHA will send written notice to you at least 30 days before the date we rescind your coverage, explaining the basis for the decision and how you can appeal it.

All faxed and mailed correspondence must be signed and dated by the affected individual or someone legally authorized to act on his or her behalf. You must complete any applications, forms, or statements requested in WHA's normal course of business or as specified in this Application/Agreement. WHA's notices to you will be sent to the most recent address WHA has for you. You are responsible for notifying WHA of any change in address. Regardless of when you notify WHA that the Applicant moved, the Applicant will no longer be eligible for coverage if he or she moves out of the service area.

Except as preempted by federal law, this Application/Agreement and the EOC/DF will be governed in accord with California law and any provision that is required to be in these documents by state or federal law shall bind you and WHA, whether or not set forth in these documents.

You or your authorized representative may request a copy of your completed application by calling 916.563.2250.

AGREEMENT

I have reviewed all responses in this Application/Agreement. With my signature below, I represent that the information provided in this Application/Agreement is complete and accurate to the best of my knowledge, and I understand and agree to the Conditions of Acceptance and the authorizations I have provided. I alone am responsible for the accuracy and completeness of the information provided on this Application/Agreement. I have personally reviewed all information provided on this Application/Agreement, even if I did not fill out the form myself. To the best of my knowledge and belief, all information on this Application/Agreement, is accurate, true and complete. If WHA determines that information on this application is materially inaccurate, not true or incomplete, I understand that coverage may be terminated or, if the inaccuracy, untruthfulness, or incompleteness was intentional, coverage may be rescinded. I further understand that I must provide WHA with any new information that arises after the submission of this application but before my enrollment with WHA begins. If I have completed this Application/Agreement on another individual's behalf, I represent that I have legal authority to sign on behalf of the Applicant.

_____ _____

Applicant/Financially responsible party (*signing on behalf of self, Applicant, or Dependent under the age of 18*) Today's Date

_____ _____

Dependent (*if over the age of 18*) Today's Date

_____ _____

Dependent (*if over the age of 18*) Today's Date

_____ _____

Dependent (*if over the age of 18*) Today's Date

Important: all Applicants age 18 or over must sign and date above on the appropriate signature line. Parent or legal guardian must sign for family members under the age of 18.

AUTHORIZATION TO RELEASE INFORMATION

All Applicants: Please read the following information and sign in the space(s) provided below.

I authorize WHA to disclose to my WHA broker or agent the status of my application for coverage, as well as that of any Applicant on whose behalf I am executing this authorization, including whether an application was received, accepted, or rejected; if accepted, the effective date of coverage; and information regarding the status of bills and payments for amounts due for coverage.

If this authorization is completed on behalf of an individual other than myself, I represent that I have legal authority to sign on behalf of that individual.

_____ _____

Applicant/Financially responsible party (*signing on behalf of self, Applicant, or Dependent under the age of 18*) Today's Date

_____ _____

Dependent (*if over the age of 18*) Today's Date

_____ _____

Dependent (*if over the age of 18*) Today's Date

_____ _____

Dependent (*if over the age of 18*) Today's Date

Important: all Applicants age 18 or over must sign and date above on the appropriate signature line. Parent or legal guardian must sign for family members under the age of 18.

WESTERN HEALTH ADVANTAGE ARBITRATION AGREEMENT

I understand and agree that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation [29 CFR 2560.503·1], certain benefit-related disputes) any dispute between myself (including any heirs or assigns) on the one hand and WHA, any contracted health care providers, administrators, or other associated parties on the other hand, including claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), shall be determined by submission to binding arbitration proceedings, The parties, including any heirs or assigns, to this Arbitration Agreement are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

_____ _____

Applicant/Financially responsible party (*signing on behalf of self, Applicant, or Dependent under the age of 18*) Today's Date

_____ _____

Dependent (*if over the age of 18*) Today's Date

_____ _____

Dependent (*if over the age of 18*) Today's Date

_____ _____

Dependent (*if over the age of 18*) Today's Date

Important: all Applicants age 18 or over must sign and date above on the appropriate signature line. Parent or legal guardian must sign for family members under the age of 18.

AGENT OR BROKER REPRESENTATIVE INFORMATION

FOR APPLICANTS USING AN INSURANCE AGENT OR BROKER

Agent or Broker Name _____

Western Health Advantage will compensate the broker of record a 5% commission per member per month with the purchase of this coverage from WHA.

TO BE COMPLETED BY YOUR AGENT OR BROKER AFTER COMPLETION OF THIS APPLICATION

You must answer the following question by selecting Yes or No:

❑ Yes ❑ No I assisted the applicant in the submission of this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the Applicant, or the Person Financially Responsible, as appropriate, in easy-to-understand language, the risk to the Applicant of providing inaccurate information, and the Applicant, or the Person Financially Responsible understood the explanation.

Notice to agent or broker: If you have assisted in the submission of this application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies available under current law.

_____ _____

Agent or Broker Signature Today's Date

Agent or Broker Representative Information

First Name_____ MI ____ Last Name _____

WHA Broker Identification Number _____

Residential Street Address _____ Apt./Unit#_____

City, State, Zip _____

Business Phone _____ Email _____

Enrollment Application/Form Supplement: Minor/Adult Dependent Information

Mail to: Western Health Advantage, Attn: Eligibility
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Fax to: 916.568.0334
Email to: eligibility@westernhealth.com
Direct questions to: 916.563.2206, 888.442.2206 toll-free or 888.877.5378 for TDD/TYY

Complete this form if the Enrollment Application/Form is A) for a minor only or B) a family plan that includes: (1) a minor dependent, (2) an adult dependent unable to make health care decisions on their own or (3) a dependent parent or stepparent who is eligible for or enrolled in Medicare*.

Applicant Name (Minor/Adult Dependent) _____ **Date of Birth** _____

Is the Subscriber or Person Responsible[i] listed on the Enrollment Application/Form a parent or guardian legally authorized to receive/release information on the minor or adult dependent applicant[ii]? ❑ YES ❑ NO

If Yes: Provide information on any **other** parent/guardian legally authorized to receive/release information on the minor or adult dependent applicant.

If No: Provide information on all parents/guardians legally authorized to represent the minor or adult dependent applicant.

First Name _____ Last Name _____ MI _____

Relationship (check one): ❑ Parent ❑ Guardian ❑ Other _____

Address _____ Apt./Unit#_____

City, State, Zip _____

Email Address _____ Phone _____

First Name _____ Last Name _____ MI _____

Relationship (check one): ❑ Parent ❑ Guardian ❑ Other _____

Address _____ Apt./Unit#_____

City, State, Zip _____

Email Address _____ Phone _____

First Name _____ Last Name _____ MI _____

Relationship (check one): ❑ Parent ❑ Guardian ❑ Other _____

Address _____ Apt./Unit#_____

City, State, Zip _____

Email Address _____ Phone _____

Does the minor/adult dependent live at the same address as the Person Responsible or Subscriber? ❑ YES ❑ NO

If No: Provide Address _____ Apt./Unit#_____

City, State, Zip _____

continued

i A Personal Representative of a minor child or adult child who is unable to make health care decisions is usually the child's parent/s or legal guardian/s. Do not list a parent if the court has removed that parent's rights with respect to the minor applicant or adult dependent.
ii Generally, a HIPAA-covered health plan like Western Health Advantage must allow Personal Representatives to request/receive protected health information on a minor. However, federal and state laws prohibit WHA from providing information on minors 12 years of age or older relating to sensitive services without written authorization from the minor.

Applicant Name (Minor/Adult Dependent) _____ **Date of Birth** _____

I have personally reviewed all information provided on this Enrollment Application/Form Supplement. To the best of my knowledge and belief, all information on this Enrollment Application/Form Supplement, is accurate, true and complete. If WHA determines that information on the Application/Form, including this Supplement, is materially inaccurate, not true or incomplete, I understand that coverage may be terminated or, if the inaccuracy, untruthfulness, or incompleteness was intentional, coverage may be rescinded. I further understand that I must provide WHA with any new information that arises after the submission of this application but before my enrollment with WHA begins.

If sole Applicant on the Enrollment Application/Form is a minor: If the sole applicant is under 18 years of age, and the Responsible Party is not the natural parent of the applicant, copies of the court papers authorizing guardianship must be submitted with the Enrollment Application/Form, or to WHA Member Services upon enrollment.

For adult dependents, copies of the court papers authorizing guardianship or conservatorship must be submitted with the Enrollment Application/Form, or to WHA Member Services upon enrollment.

Responsible Party (on behalf of Applicant or Dependent) Name (print) _____

Signature_____ Date _____

*For additional information concerning covered benefits for a dependent parent or stepparent who is eligible for or enrolled in Medicare, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. HICAP provides health insurance counseling for California senior citizens. Call the HICAP toll-free telephone number, 1.800.434.0222, for a referral to your local HICAP office, or see the listing provided below. HICAP is a service provided free of charge by the State of California.

El Dorado, Placer, Sacramento, and Yolo Counties	Address: 505 12th Street, Sacramento, CA 95814 Telephone: 916.376-8915 (Monday – Friday: 9 a.m. – 4 p.m.)
Marin, Napa, Solano, and Sonoma Counties	Address: 1129 Industrial Ave, Suite 201, Petaluma, CA 94954 Telephone: 707.526.4108 (Monday – Friday: 9 a.m. – 3 p.m.)

Western Health Advantage complies with applicable Federal and California civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, as applicable. Western Health Advantage does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Western Health Advantage:

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 these services, contact the Member Services Manager at 888.563.2250 and find more information online at https://www.westernhealth.com/legal/non-discrimination-notice/.

If you believe that Western Health Advantage has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance by telephone, mail, fax, email, or online with: Member Services Manager, 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833, 888.563.2250 or 916.563.2250, 888.877.5378 (TTY), 916.568.0126 (fax), memberservices@westernhealth.com, https://www.westernhealth.com/legal/grievance-form/. If you need help filing a grievance, the Member Services Manager is available to help you. For more information about the Western Health Advantage grievance process and your grievance rights with the California Department of Managed Health Care, please visit our website at https://www.westernhealth.com/legal/grievance-form/.

If there is a concern of discrimination based on race, color, national origin, age, disability, or sex, 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:

Website: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf; Mail: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; Phone: 800.368.1019 or 800.537.7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ENGLISH
If you, or someone you're helping, have questions about Western Health Advantage, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 888.563.2250 or TTY 888.877.5378.

SPANISH
Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Western Health Advantage, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 888.563.2250, o al TTY 888.877.5378 si tiene dificultades auditivas.

CHINESE
如果您，或是您正在協助的對象，有關於 Western Health Advantage**方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話**888.563.2250**或聽障人士專線**(TTY) 888.877.5378**。**

VIETNAMESE
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Western Health Advantage, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số 888.563.2250, hoặc gọi đường dây TTY dành cho người khiếm thính tại số 888.877.5378.

TAGALOG
Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Western Health Advantage, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 888.563.2250 o TTY para sa may kapansanan sa pandinig sa 888.877.5378.

KOREAN
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Western Health Advantage에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 888.563.2250이나 청각 장애인용 TTY 888.877.5378로 연락하십시오.

ARMENIAN
Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի Western Health Advantage-ի մասին, Դուք իրավունք ունեք անվճար օգնություն և տեղեկություններ ստանալու Ձեր նախընտրած լեզվով: Թարգմանչի հետ խոսելու համար զանգահարե՛ք 888.563.2250 համարով կամ TTY 888.877.5378՝ լսողության հետ խնդիրներ ունեցողների համար:

PERSIAN-FARSI
اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Western Health Advantage (وسترن هلث اَدونتیج) داشته باشید حق این را دارید که کم کی اطلاعات به زبان خود را به طور رایگان دریافت نمایید. لطفا با شماره تلفن 888.563.2250 تما سگیرید. افراد ناشنوا می توانند به شماره888.877.5378 پیام تایپی ارسال کنند

RUSSIAN
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Western Health Advantage, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 888.563.2250 или воспользуйтесь линией TTY для лиц с нарушениями слуха по номеру 888.877.5378.

JAPANESE
ご本人様、またはお客様の身の回りの方でも、Western Health Advantageについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、888.563.2250までお電話ください。聴覚障がい者用TTYをご利用の場合は、888.877.5378までお電話ください。

ARABIC
إن كان لديك أو لدى شخص تساعده أسئلة بخصو صWestern Health Advantage، فلديك الحـ وقي الحصو لعلى المساعدة والمعلومات الضرو رية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 888.563.2250، أو برقم الهاتف النصي (TTY) لضعاف السمع 888.877.5378.

PUNJABI
ਜੇਕਰ ਤੁਸੀਂ, ਜਾਂ ਜਿਸ ਕਿਸੇ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਦੇ Western Health Advantage ਬਾਰੇ ਸਵਾਲ ਹਨ ਤਾਂ, ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 888.563.2250 'ਤੇ ਜਾਂ ਪੂਰੀ ਤਰ੍ਹਾਂ ਸੁਣਨ ਵਿੱਚ ਅਸਮਰਥ ਟੀਟੀਵਾਈ ਲਈ 888.877.5378 'ਤੇ ਕਾਲ ਕਰੋ।

CAMBODIAN-MON-KHMER
ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលកំពុងជួយអ្នក មានសំណួរអំពី Western Health Advantage ទេ, អ្នកមានសិទ្ធិទទួលជំនួយនឹងព័ត៌មាន នៅក្នុងភាសារបស់អ្នក ដោយមិនអស់ប្រាក់។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូមទូរស័ព្ទ 888.563.2250 ឬ TTY សម្រាប់អ្នកត្រចៀកធ្ងន់ តាមលេខ 888.877.5378។

HMONG
Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Western Health Advantage, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 888.563.2250 los sis TTY rau cov neeg uas tsis hnov lus zoo nyob ntawm 888.877.5378.

HINDI
यदि आप, या जिस किसी की आप मदद कर रहे हो, के Western Health Advantage के बारे में प्रश्न हैं तो, आपको अपनी भाषा में मदद तथा जानकारी प्राप्त करने का अधिकार है। दुभाशिए के साथ बात करने के लिए, 888.563.2250 पर या पूरी तरह श्रवण में असमर्थ टीटीवाई के लिए 888.877.5378 पर कॉल करो।

THAI
หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Western Health Advantage
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย เพื่อพูดคุยกับล่าม โทร 888.563.2250 หรือใช้TTY สำหรับคนหูหนวกโดยโทร 888.877.5378